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City of
BRADFORD
METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Children's Services Overview and Scrutiny Committee to be held on Wednesday, 13 March 2024 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT	BRADFORD INDEPENDENT GROUP
Fricker **Mohammed** **Regan** **Thirkill** **Zaman**	**Davies** **Pollard**	**Sunderland**	**Sajawal**

Alternates:

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT	BRADFORD INDEPENDENT GROUP
Alipoor **Berry** **Humphreys** **I Hussain** **Walsh**	**Birch** **Felstead**	**Naylor**	**Elahi**

VOTING CO-OPTED MEMBERS:

Church Representative:
Joyce Simpson
Position Vacant

Parent Governor Representatives:
Shifa Simab
Position Vacant

NON-VOTING CO-OPTED MEMBERS:

Teacher Secondary School Representative:
Tom Bright

Notes:

- This agenda can be made available in Braille, large print or tape format on request by contacting the Agenda contact shown below.
- The taking of photographs, filming and sound recording of the meeting is allowed except if Councillors vote to exclude the public to discuss confidential matters covered by Schedule 12A of the Local Government Act 1972. **Recording activity should be respectful to the conduct of the meeting and behaviour that disrupts the meeting (such as oral commentary) will not be permitted. Anyone attending the meeting who wishes to record or film the meeting's proceedings is advised to liaise with the Agenda Contact who will provide guidance and ensure that any necessary arrangements are in place**. Those present who are invited to make spoken contributions to the meeting should be aware that they may be filmed or sound recorded.
- **Members of the public are respectfully reminded that this is a meeting that is being held in public NOT a public meeting. The attendance of the public to observe the proceedings is welcome.**
- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From:
Jason Field
Interim Director of Legal and Governance
Agenda Contact: Kav Amrez / Louis Kingdom
Phone: 07929 070288/07890 416570
E-Mail: kanwal.Amrez2@bradford.gov.uk/louis.kingdom@bradford.gov.uk

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The Director of Legal and Governance will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct – Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members must consider their interests, and act according to the following:

Type of Interest	***You must:***
Disclosable Pecuniary Interests	*Disclose the interest; not participate in the discussion or vote; and leave the meeting unless you have a dispensation*
Other Registrable Interests (Directly Related) ***OR*** *Non-Registrable Interests (Directly Related)*	*Disclose the interest; speak on the item only if the public are also allowed to speak but otherwise not participate in th discussion or vote; and leave the meeting unless you have a dispensation*
Other Registrable Interests (Affects) ***OR*** *Non-Registrable Interests (Affects)*	*Disclose the interest; remain in the meeting, participate and vote unless the matter affects the financial interest or well-being* *(a) to a greater extent than it affects the financial interests of a majority of inhabitants of the affected ward, and* *(b) a reasonable member of the public knowing all the facts would believe th*

it would affect your view of the wider public interest;in which case speak or the item only if the public are also allowed to speak but otherwise not do not participate in the discussion or vote; and leave the meeting unless you have a dispensation.

(2) Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(3) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. MINUTES

Recommended –

That the minutes of the meeting held on 24 January 2024 be signed as a correct record (previously circulated).

(Kav Amrez / Louis Kingdom – 07929 070228 / 07890 416570)

4. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Kav Amrez / Louis Kingdom – 07929 070228 / 07890 416570)

5. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

6. APPOINTMENT OF NON-VOTING CO-OPTED MEMBERS

The Committee is asked to confirm and recommend to Council the appointment of the following non-voting co-opted representative for the 2023/2024 municipal year:

NON VOTING CO-OPTED MEMBERS:

Children's Social Care – Rosie Tejani

(Kanwal Amrez/Louis Kingdom – 07929 070288/07890 416570)

B. OVERVIEW AND SCRUTINY ACTIVITIES

7. AN UPDATE ON AUTISM AD ADHD ASSESSMENT AND SUPPORT 1 - 220

The report of the Director for Health and Care Partnership **(Document "U")** provides an update from the Healthy Minds programme for Bradford District and Craven. The focus of the report is an update on the current context and complexity that includes system challenges for assessment waits and Attention Deficit Hyperactive Disorder (ADHD) medication. The report will highlight the work currently taking place across our Partnership, including support that is being provided to those that are waiting.

Recommended –

(1) That the committee are asked to note the update that sets out our approach to mitigating some of the significant challenges to ensure children and young people in Bradford District and Craven are supported.
(2) That the committee are asked to support us in setting out towards a needs-led system and recognise the community engagement needed.
(3) That the committee is asked to support efforts to raise awareness of the Healthy Minds website (www.healthyminds.services/) and the Local Offer website (https://localoffer.bradford.gov.uk/) which is specifically for those looking for help with SEND related services.

(Emma Hughes – 07976590243)

8. EDUCATIONAL STANDARDS - EARLY YEARS TO KEY STAGE 4

221 - 246

The Strategic Director Children's Services will submit a report **(Document "V")** which provides an update on the outcomes from national assessments for primary and secondary pupils for the academic year 2022/23 and updated information on the outcomes of Ofsted inspections within education settings.

Recommendations –

That the Committee notes the contents of this report.

(Richard Crane – 01274 432009)

City of
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METROPOLITAN DISTRICT COUNCIL

Report of the Director for Health and Care Partnership to the Children's Overview & Scrutiny Committee to be held on 13th March 2024

U

Subject: An update on Autism and ADHD assessment and Support

Summary statement:

This report provides an update from the Healthy Minds programme for Bradford District and Craven. The focus of the report is an update on the current context and complexity that includes system challenges for assessment waits and Attention Deficit Hyperactive Disorder (ADHD) medication. The report will highlight the work currently taking place across our Partnership, including support that is being provided to those that are waiting.

Directors: Phillipa Hubbard, Sarah Muckle, Sasha Bhat

Report Authors:
Emma Hughes, Christina Holloway, Sarah Exall, Sasha Bhat

Report Contact:
E-mail: emma.hughes@bradford.nhs.uk

Portfolio:

Healthy Minds

1. Summary

1.1. Meeting the demand for Autism and Attention Deficit Hyperactive Disorder (ADHD) assessments is a national challenge with a similar picture across Bradford District. The report will outline the context for this, and the work undertaken to address this, while recognising that national issues - such as availability of trained workforce - continues to hamper efforts.

1.2. This report will focus on children and young people.

1.3. This report will outline some of work that has taken place to ensure children, young people and families are receiving support while waiting for assessment and post assessment

1.4. The report will reference the challenge for ADHD medication, again this is set against a national issue affecting medicine supply.

1.5. The report provides definitions of the different conditions, this forms part of our efforts to raise awareness, understanding and tackle stigma as part of our efforts to become a neurodiverse friendly place.

1.6. We seek the support of Members of Children's Services Overview and Scrutiny Committee in assisting us to supporting our families and communities by sharing the support available and having the awareness of the challenges faced. As we move towards a needs-led system, we recognise that we need to take families and communities on the journey with us, if we want to reduce the demand for diagnosis.

2. Definitions

2.1 Neurodiversity

'Neurodiversity' is the understanding that people think and feel, experience and interact differently with the world; that these differences are normal and to be expected and celebrated, not treated as deficits.

Autism, ADHD, dyslexia and dyspraxia are examples of neurodevelopmental conditions. They are 'spectrum' conditions, which means they come with a wide range of characteristics.

Autism, ADHD and other neurodevelopmental conditions are diagnosable by a trained professional. Only a small minority of any population will meet the threshold for diagnosis. A larger proportion will share some neurodivergent traits and characteristics, without meeting those diagnostic thresholds.

2.2 Autism

Autism is a complex, lifelong developmental condition that typically appears during early childhood. It is a spectrum condition that affects individuals to varying degrees. The diagnostic criteria stipulate individuals will have persistent difficulties with social communication and social interaction and will have restrictive and repetitive patterns of behaviours, activities and interests that limit and impair everyday functioning.

2.3 Attention Deficit Hyperactive Disorder (ADHD)

Attention Deficit Hyperactive Disorder (ADHD) is a condition where children and young people show a persistent pattern of inattention and/or hyperactivity–impulsivity that interferes with day-to-day functioning and/or development and is pervasive.

3. Autism and ADHD Assessment

3.1 The autism assessment pathway is considered to have five stages:

1. identification and referral
2. screening and triage
3. pre-assessment support
4. autism assessment
5. post-assessment support

While it is the responsibility of health partners to deliver the assessment, the whole pathway, i.e. the identification and referral, the screening and triage and the pre- and post - assessment support benefit from a partnership approach to ensure children and young people receive the support and care needed ahead of, and after, an assessment.

3.1 Autism and ADHD Assessment waiting times

3.1.1 NICE waiting time standard is 13 weeks from referral to the start of an assessment. This is a non-mandatory standard, which for neurodiversity assessments is rarely achieved by NHS or private providers. Assessment and diagnosis of autism: what to expect - Quick guides | NICE Communities

3.1.2 Notwithstanding three business cases since 2018 to increase resource into the Autism and ADHD assessment pathway, challenges remain. This is due to numerous national challenges, such as the availability of a trained workforce and the increase in demand and the complexity of cases and awareness. In addition, we are aware and concerned by the proliferation of unreliable tools, sometimes available online or as smartphone apps, that claim to be able to screen for autism. The use of such a tool should not be seen as an alternative to proper assessment and diagnosis. However we recognise people use such tools and this creates further demand and expectations.

3.1.3 Since 2020, the demand for assessments has risen by 122% in Bradford District and Craven Health and Care Partnership (BDC). There is a rise of requests for dual (both Autism and ADHD) assessments. The current waits are approximately 140 weeks. There is approximately 300 referrals a month, with capacity to complete 88 referrals per month. This challenge is not unique to BDC, with other regional partners reporting similar and higher increases in waiting times.

3.1.4 There is a significant workforce challenge nationally with the availability of staff identified that can carry out/confirm Autism and ADHD diagnosis. Workforce challenges are further impacted by the rise in private providers in the region (note this is different to the private providers we have selected to help reduce waiting times).

3.1.5 BDC continued to offer assessment in the pandemic, which did positively affect waiting times, when comparing to regional partners.

3.1.6 Since 2021, schools are now able to make direct referrals for both Autism and ADHD assessment. Schools are now the biggest referrer for these assessments.

3.1.7 BDC are assured that the right CYP are being referred for assessment as 91% of all referrals go on to receive a diagnosis.

3.1.8 To try and reduce waiting times, BDC has outsourced 16080 cases to private providers since 2021. All vacancy factor monies, from unfilled and vacant posts, available across all providers has been used to further outsource, and this will continue.

3.1.9 Although waits for assessment are significantly longer than we would like due to both resource and workforce issues, the quality of assessments continues to remain in line with NICE guidelines and recommendations in both the under 7 and over 7 assessment pathways.

3.1.10 In order to ensure that those CYP that have significant vulnerabilities are not further disadvantaged a clinical prioritisation criterion has been implemented to ensure these children do receive timely assessment within 13 weeks.

3.1.11 BDC has worked hard to remove any prerequisite of needing a diagnosis to access support from health and education services, with access being led by needs not diagnosis.

3.2 Special Educational Needs and Disabilities (SEND) Written Statement of Action

3.2.1 In March 2022 Bradford received a ‘Written Statement of Action’ following the joint OFSTED/CQC local area SEND inspection in March 2022.

3.2.2 This identified an area of weakness in relation to a number of areas including children and young people wait too long for assessments, treatment and diagnosis. There is insufficient support for children and young people with SEND who are waiting for provision, services, diagnosis or equipment.

3.2.3 One of those areas identified in the 2022 inspection feedback was Autism wait times were too long and children and families lacked information, support and signposting to support them waiting well, whist on the waiting list.

3.2.4 The WSOA action plan included – ‘Reducing waiting times for autism / ADHD assessment and strengthen the support offer whilst waiting for assessment’ and included:

- The Autism/ADHD service pathway is mapped, and all key stakeholders are aware of current service offer by March 2023
- Referral criteria is reviewed and signed off and is shared with key stakeholders including children, young people and families by March 2023
- Self-help, Universal and Early Help pathway is agreed by March 2023
- Delivery of the support pathway for Autism / ADHD from self-help, universal offer and early help services by September 2023
- Evidence of signposting to support whilst waiting for Autism/ADHD assessment by March 2023

3.2.5 There have been three monitoring visits following on from the March 2022 SEND inspection outcome and the development of the agreed WSOA plan initiated from September 2022. Assurance of BDC approach to Autism and ADHD has been sought at each monitoring visit.

3.2.6 During the October 2023 monitoring visit both the Department of Education (DfE) and NHS England were provided with additional information relating to Autism and ADHD and were able to acknowledge the challenges in our local area as well as the efforts the local system were undertaking. The DfE Commissioned SEND Adviser stated ‘It was demonstrated that children can now access the services they require regardless of whether they have a ‘diagnosis’ or not’.

3.2.7 The Bradford district Local Area fourth SEND monitoring visit on 19 March 2024, will again seek information and progress in the system for Autism and ADHD assessment, provision and support and outlines steps to monitor impact and outcomes for CYP.

3.2.8 Autism and ADHD remain a key priority to address within our system, and this is evidenced by the Self Evaluation Framework (SEF), the Local Area Inclusion Plan (LAIP) and within both the Healthy Children and Family Board and Healthy Minds Board strategies.

3.3. Support while waiting and for those diagnosed – waiting well

3.3.1 This work forms part of our wider strategic ambition of keeping people happy healthy and at home, by ensuring a clear purpose to what we do, within our place through partnership working to support our population. We recognise there is work needed to provide support for children and young people while they are waiting for assessment.

3.3.2 BDC have good quality support services available for the population, however these are often locality based and have small resource associated. The ICS have been implementing and directing investment to help support more CYP with or without a diagnosis. BDC has removed any requirement for a formal diagnosis to access support from all services.

3.3.3 The following services have been developed, expanded or continue to be provided to those CYP that need them, regardless of a diagnosis:

- The **local offer**, **Healthy Minds** and **CAMHS** website with consistent information around the assessment process and support offer

- **Clinical prioritisation criteria** has been increased to ensure those most vulnerable are expedited for assessment. The criteria now includes, the Dynamic Support Register (DSR) cohort, CYP that have been excluded from school or are in alternative provision, children looked after, asylum seekers and refugees, CYP known to youth justice services and those at risk of a mental health admission.

- **Removing barriers to access support** as part of the SEND work, services will no longer require a diagnosis to access the support on offer. The support offers in BDC will be provided based on need.

- Ensuring universal offers that are provided, can meet the needs of neurodiversity within their existing offers to ensure all services are inclusive. Examples include:
    - Little Minds Matter
    - 0-19 Service
    - Family hubs
    - Mental Health Support Teams
    - Special early attachment development service

- **School being able to make referrals for Autism and ADHD assessments** have supported schools to better identify and meet need based on the evidence and information they provide to make the referral, enabling reasonable adjustments to be made in schools and if necessary, support plans and education health and care plans to be implemented.

- **Parent and carer networks** based on peer support, operating from schools – providing drop-ins, peer support to CYP and families and school-based support.

- **Barnardo’s care navigator role** (a lived experience post) is now in place, working as peer support offer for those waiting to sign post to support and offer peer support sessions to struggling families. This is available on all children and young people pathways.

- **Continue to work with Voluntary Community and Social Enterprise Sector (VCSE),** which includes both AWARE and the Parent carer network. **Aware** provide a commissioned offer from **Bradford Early Advice Team (BEAT)** to families of those on waiting lists. This is well evaluated, and reoccurring funding. **The Parent Carer network** based on peer support, operating from schools, provides drop-ins and peer support. we are continually working hard to ensure we are reaching our diverse communities and are currently connecting with **Bradford Stronger Together** to meet the needs of the parents and families from our diverse inner-city communities. **Specialist Autism Services** delivers a strengths-based Autism specific personalised learning programme, to develop social, communication and employment skills which empower members to engage with new opportunities, make informed choices, achieve their goals, maximising independence and inclusion.

- We have recently set up **Brad Starz**, a SEND youth voice group for people aged 14-24 who meet to discuss things that matter to them. Brad Starz is a group for young people aged between 14 and 24 that live or go to a school within the Bradford District and have a Special Educational Need and/or Disability (SEND)

  - **Social Prescribing** offer for children and young people with learning disabilities and Autism in four primary care network areas. This is well evaluated and we are working to see if this can be expanded.

  - **Sleep support services.** This is a new service which commenced in Oct 2023 and is being provided by **The Together Trust**. This service shares referrals closely with the **Children's Community Support Team** to offer a tiered offer of support. Evidence demonstrates that many of the families accessing the Together Trust have identified as having Autism or ADHD.

- **Development of an Avoidant Restrictive Food Intake Disorder (ARFID) service**. The CYP that will predominantly access this specialist service are likely to have neurodiverse needs.

- **Autism Strategy being developed –** this will be all age and cover culture, arts, leisure, business and education.

- **Autism Hub** Bradford and Craven Autism AIM is a service for autistic adults living in Bradford (aged 18+) with little to no funded support. They will work with 17-year-olds as they transition into adulthood to let them know what services are available once they turn 18. They provide support to access your GP, information and signposting, and one-to-one peer support. They also run a mental health peer support group.

- **Neurodiversity Social Work Service** the Neurodiversity team is a hub of Social Workers and Occupational Therapists who are dedicated and skilled to work with people aged 18 + with autism and/or other Neurodiverse conditions. The team will be based within the Learning Disability and Preparing for Adulthood Service and sit alongside the existing Learning Disability Locality Teams.

- **Schools are rolling out Autism Education Trust –** Whole school approach in Autism- District Wide and led by Local Authority

- **Educational Psychology Service** – Work in a traded way for Bradford schools and on a referral basis with no diagnosis required. They can provide an individual or whole school/class advice around neurodiversity. This team are also involved in the neurodiversity Future Pathways project – approximately 38 schools are now trialling the Electronic Developmental Support Tool (EDST) which helps settings identify reasonable adjustments and teaching practices required to support YP who may be neurodivergent.

- **My Needs App** (Myne App) which supports Autistic and neurodiverse people to communicate their needs to healthcare and other services and can improve their experience and access of services. This App is in development and being codesigned. This is funded by West Yorkshire.

- **Kindness, Compassion and Understanding campaign** – this is a young people led campaign that addresses themes of bullying in schools. Young people have driven this work and it's rolled out across schools in Bradford District and Craven. This has reached over 12,000 children with a specific cohort working with special schools – reaching 2014 children aged 4-19.

- Most children and young people in the district spend a large proportion of their time in school. School can be both supportive and pressurised environments for children and young people. This is particularly true for those with autism and ADHD, who are at higher risk of experiencing mental health problems. We have a range of offers in schools to meet the social, emotional and mental health needs of and children and young people, and the staff supporting them. For example:
    - Mental Health Support Teams (MHSTs) are currently active in 45% of schools in Bradford District, expanding to 65% by 2025.
    - Schools without a MHST are supported by the Education-based Emotional Wellbeing Practitioners (EEWPs)
    - Both the above teams deliver a range of services, including training for school staff, group work and individual support for children and young people which includes autism awareness.
    - The educational psychology team runs the Bradford Healthy Minds Chartermark programme. This is a whole school approach to mental health, supporting schools to embed good practice into their day-to-day work;
    - A youth worker is attached to every school in the district to support students;
    - All schools have been invited to take up the School Nursing offer. This offers a range of services including drop-in clinics, and 1:1 support for children and young people with specific needs;
    - Healthy Minds has produced a Directory of Mental Health Services (healthyminds.services/assets/pdfs/hm_thrive_a5_150923.pdf) to help schools to navigate the wide range of mental health services on offer in school and in the community.

3.2.1 **DATA One (Digitally Acting Together as One) programme** the team at Born in Bradford's Centre for Applied Education Research have delivered a series of **research projects**.

3.2.2 These offer new insights into the prevalence of autism across Bradford; the experiences of different communities in accessing assessment and support; and practical recommendations on how systems might be adapted to address disparities such as gender, ethnicity and poverty. These proposals have been published. The Committee may wish to review the report here. The ICS can evidence progress moving towards some of these recommendations.

3.2.3 **Shared unit on autism on the SystmOne platform**, which will be used by all three of the trusts delivering assessments to children. This will improve both information security and the quality of data available to oversee and hold systems accountable.

3.2.4 **Electronic Developmental Support Tool (EDST)** – Is the development of a digital tool to help teachers identify and meet the needs of children with neurodiversity. This is currently about to enter into phase 2 of the pilot and will cover key stage one settings in 43 Bradford and Craven primary schools. For the first time, the tool will include a ‘Digital Advice Bank’, so that as teachers identify children’s support needs, they are immediately able to find evidence-based approaches and techniques, which they can start using straight away.

3.2.5 **Data1** is about improving the neurodiversity pathway by implementing a needs-based approach throughout education and creating neuro diverse friendly environments. These will be developed in partnership with families, communities and professionals to achieve improved:

- Neurodiversity awareness in communities and at school
- Neurodiversity friendly environments
- Helpful advice and strategies in school and at home
- Identification of need via a new neuro diversity profiling tool in schools that will accurately identify (not a formal diagnosis) autism, ADHD and developmental language delay which will provide a suite of targeted support and advice.
- Improved Information sharing
- Access to diagnosis if still needed.

3.2.6 If Data1 is implemented district wide, the delivery of timely assessments will still remain a key part of this new systems approach for the majority of CYP.

3.2.7 **Neurodiverse city:** We want Bradford District and Craven to become a neurodiverse friendly district. We need to improve understanding of neurodiversity among the general population as well as those working with neurodiverse individuals. Being ‘neurodiverse friendly’ means adapting and creating inclusive environments, places, policy and services in which everyone can thrive – both people with diagnosable neurodivergent conditions and those with neurodivergent traits. We will use the opportunities that the UK City of Culture Bradford 2025 brings to accelerate this ambition. As part of this work we have:

- Launched the Neurodiverse city ambition in November 2023 with business and local organisations – this is aimed at ensuring we create good practices, tools and resources for people who are neurodiverse to access all opportunities. Examples shared on the day included the **sensory rooms at Broadway** and the **Alhambra’s inclusive approach to recruitment** and employment.
- Sharing lived experience of people and families
- Developing resources – the team are building capacity across the district, to adapt environments. This includes making resources available, where needed.
- Working with UK City of Culture Bradford 2025 to ensure the programme is neurodiverse friendly and people are employed/involved.

3.2.8 **Healthy Minds strategy:** In January 2024, we launched our district wide Healthy Minds strategy and set out our approach to achieving key ambitions. With regards to Neurodiversity, our shared outcomes will be:

- Bradford District and Craven to become a neurodiverse friendly district.
- More people are accessing support within their local communities to live independently.
- There will be a wider range of support and accommodation options for people with Autism and Sensory Impairments

- Increase the number of people recruited to and retaining meaningful employment.

The full strategy be found in the appendix.

3.3 West Yorkshire Deep Dive

3.3.1 This work commenced in March 2022 with the focus being across all ages for both Autism and ADHD. All five West Yorkshire places are represented as part of this work.

3.3.2 Objectives to work on together during 2023/2024:

- To improve consistency in Autism and ADHD services, reduce wait time and to access assessment
- to improve the availability of person centred, needs led, holistic support
- to implement the ‘Right To Choose’ agenda consistently across West Yorkshire
- To continue to embed co-production in the neurodiversity review, working with people with lived experience and professionals to create shared perspectives and learning to shape services.

3.3.3 To date there has been two West Yorkshire events that have taken place, the first of a series of Summits took place in December 2023 and the second Summit took place in February 2024. There has been good representation from Bradford at these events across health, social care, VCSE and the local authority.

3.3.3 This work has included extensive consultation and engagement with all stakeholder groups including people with lived experience, parent and carers and clinicians across all five places.

3.3.4 To achieve these objectives there will be task and finish groups and key areas of work:

- **Right to choose**, which will include co-producing information and resources to the public.
- **Data** work has started that will look at consistent metrics and collection of date for autism and ADHD.
- **Assessment pathways** evaluate and share learning from pilots, working together and developing digital resources.

3.4 ADHD Medication

This provides a brief overview of some the recent medication challenges for ADHD

3.4.1 A high proportion of CYP diagnosed with ADHD go on to receive medication for the condition. With the rise in diagnosis, there has been a rise in ADHD medication prescribed.

3.4.2 Only a healthcare professional (specialist pharmacist, non-medical prescriber or medical practitioner) can initiate and continue to prescribe ADHD medication. Workforce challenges remain for these professions.

3.4.3 Since September 2023, there has been a national shortage of ADHD medication. National guidance provided stated that there should be a pause on commencing new people on medication, to protect the supply for those already established on medication.

3.4.4 This was due to resolved by December 2023, however a new date has been provided of April 2024 by NHS England. Waiting times have increased as a direct result of this national shortage, however the section below will highlight what we are doing to support those that are waiting.

3.4.5 Clinical prioritisation criteria continue to be implemented to ensure those that are vulnerable and at risk are maintained on their medication.

In summary, we recognise that waiting times are long and demand is increasing. The partnership approach enables us to see children and young people in the whole. We have invested in a series of support and care approaches both in school and within pathways to ensure children and young people can access support regardless of a diagnosis. We have used private providers to maintain pace with assessment while work takes place at local, regional and national place to address the challenges of training, workforce and medication access.

4. Options

4.1. There are no options associated with the strategy or service deep dive

5. Recommendations

5.1. The committee are asked to note the update that sets out our approach to mitigating some of the significant challenges to ensure children and young people in Bradford District and Craven are supported.

5.2. The committee are asked to support us in setting out towards a needs-led system and recognise the community engagement needed.

5.3. The committee is asked to support efforts to raise awareness of the Healthy Minds website (www.healthyminds.services/) and the Local Offer website (https://localoffer.bradford.gov.uk/) which is specifically for those looking for help with SEND related services

6. Background documents

6.1. There are no background documents

7. Not for publication documents

7.1. There are no not for publication documents

11. Appendices

Autism: A National Framework (Appendix 1)

NHS England » A national framework to deliver improved outcomes in all-age autism assessment pathways: guidance for integrated care boards

OFSTED/CQC SEND Inspection WSOA action plan (Appendix 2)

20220920_Bradford_WSOA_v4.2.docx

Choice in Mental Health care (P44) (Appendix 3)

choice-in-mental-health-care-v5 (2).pdf

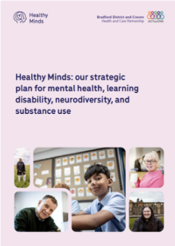
Autism Assessment and Support Crisis- Child of the North (Appendix 4)

CotN-Digital-Pages.pdf

Clinical Prioritisation Criteria

Clinical Priority for Neurodevelopment A

Healthy Minds Strategy



Healthy Minds: our strategic plan for mental health, learning disability, neurodiversity, and substance use

Local Area Inclusion Plan

Self Evaluation Framework

- Bradford Local Offer
- Healthy Minds – Mental health support in Bradford and Craven
- CAMHS Neurodevelopmental team - BDCT

Bradford District and Craven
Health and Care Partnership
ACTasONE

Proud to be part of the West Yorkshire Health and Care Partnership

HELP AND INFORMATION FOR FAMILIES WITH SPECIAL NEEDS AND DISABILITIES
BRADFORD AND DISTRICT LOCAL OFFER
LO

The Parents' Forum for Bradford and Airedale

SEND NO LIMITS

Joint area SEND inspection in Bradford

Written Statements of Action September 2022

City of BRADFORD
METROPOLITAN DISTRICT COUNCIL

NHS
NHS West Yorkshire
Integrated Care Board

Foreword

Between 7 and 11 March 2022, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Bradford to judge the effectiveness of the district in implementing the disability and special education needs reforms as set out in the Children and Families Act 2014.

On 8 June 2022 the inspection report for Bradford district was published and because of the findings in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015; Her Majesty's Chief Inspector (HMCI) has determined that a Written Statement of Action (WSOA) is required because of five areas of significant weakness in the local area's practice. City of Bradford Metropolitan District Council (CBMDC), and the local NHS responsible commissioner, West Yorkshire Integrated Care Board (ICB), are jointly responsible for submitting the written statement to Ofsted.

The WSOA will explain how we plan to improve the following areas of significant weakness:

1. Poor communication between stakeholders across education, health and care.
2. The variable quality of EHC plans, including plans which do not fully describe the provision that children and young people with SEND need.
3. The inconsistent delivery of the 0 to 19 health visiting, school nursing and specialist nursing services.
4. Children and young people wait too long for assessments, treatment and diagnosis. There is insufficient support for children and young people with SEND who are waiting for provision, services, diagnosis or equipment.
5. Education, health and care services do not work together well. The arrangements for joint commissioning are underdeveloped.

Our Local Area Inspection identified several areas in which we must improve, and we have resolved to make these improvements and more. This action plan sets out how the Council and the ICB will work together with partners, including parents/carers, young people and school leaders, to improve outcomes for children and young people with special educational needs and/or disabilities (SEND).

This plan, working with partners across our District, will provide the drive and ownership to improve the areas Ofsted have identified as requiring a Written Statement of Action (WSOA) for driving forward the improvements we need to make.

The Local Area is committed to improving support, services and provision for children, young people, parents and carers in Bradford. We are committed to working in partnership, increasing co-production, and harnessing the expertise within the system; including parents/carers, children, young people and the staff who work to support them. We are committed to ensuring that the parents, carers and the children and young people with SEND themselves are directly and transparently involved in co-producing the services that support them; so that that they receive high quality education, care and health provision. We will work across our wider partnership to understand experiences, improve services, and to secure the trust of families.

Ofsted in their inspection felt we knew ourselves well. They felt we had identified the areas we needed to improve on to provide better outcomes for children, young people and their families in Bradford. We have been working with a wide range of partners following the inspection to help shape the activities contained within this Written Statement. We have met with educational leads and schools including the Bradford Schools Partnership (BSIP), Schools Forum, Local Area Partnership (LAP) and BD3 Heads Group, to help frame the infrastructure and approaches we need to move forward. We have also been working with Parent and Carer Groups including the Parent Carer Forum, Snoop and Aware to help co-produce new models of working that we are rolling out over the next 12 months. We have also engaged with key health partners, including operational service leads, senior health provider leads and Chief Nurses.

Senior leaders in Bradford will prioritise the delivery of the actions outlined within this statement of action and will ensure robust scrutiny of progress resulting in improved services and making the best use of the resources available for SEND.

This Written Statement of Action has been approved and endorsed by: Bradford District Council Cabinet and Bradford District and Craven Health and Care Partnership Leadership Executive.

TABLE OF CONTENTS

Introduction

We have a shared commitment to making the district a great place to be a child and young person. We want to put the voice of the child and children's rights at the heart of the decision making and delivery of all that we do. We will support children to be as healthy and well as possible and we will reduce inequalities in educational attainment.

Our SEND Strategy ***SEND: no limits!*** sets out the vision and strategic priorities for the Bradford Local Area. As multi-agency partners we will make sure we improve the outcomes and reduce inequalities for all children and young people with SEND in Bradford District, so that they flourish and reach their potential.

Our SEND Joint Commissioning Strategy shares our approach to working together. At the heart of our approach is our ambition for effective co-production and engagement with parents, carers and professionals, having an equal and mutual respect for each other's views, with open and honest relationships. We will continue to be transparent and continually evolve to achieve meaningful and positive outcomes together.

We know that we need to improve the quality of our Education, Health and Care (EHC) plans. We have now achieved a position where we are in the top half of all local authorities nationally, in terms of timeliness of plans to families, which is a positive. We also know the contribution of all partners to plans and their timely review is a priority for us moving forward.

We have listened to feedback from the CQC on the school nursing, health visiting and specialist school nursing service and the delivery of the Healthy Child Programme. We are engaging in a period of review and redesign, to ensure these services meet the needs of children and families in the district.

We are also in the process of seeing how we can effectively jointly commission services for SEND as part of the new Integrated Care Partnership (ICP) arrangements. We are also determined to ensure that we co-design and shape all our services to meet the needs of children and families in the Bradford local area, who receive universal and specialist services, so we can best support them.

Our Children and Young People's Plan recognises we have challenges to overcome if we are to ensure our children can thrive physically, intellectually and emotionally. One of our key principles as a Partnership is to support children to maximise their learning, growth and development and to remain happy, healthy at home, and wherever possible to be brought up and cared for within their own families. This means working with, and supporting, the whole family as early as possible to address issues that can prevent children and young people from thriving, learning, growing and developing.

We want Bradford to be a great place to be a child – a place where all our children and young people are given the best start in life and can fully develop their talents and abilities. We will work tirelessly to reduce the educational attainment gap and ensure no child is left behind so that our most vulnerable children and young people are protected. Education and schooling should be an engine of opportunity that maximises our children and young people’s life chances and prepares them for successful transitions into adult life, whatever their background.

We want all our children and young people to enjoy the prospect of safe, long, happy and fruitful lives by improving their health and socio-economic wellbeing. We will work to address the underlying causes of poor health, in particular the influence of poverty and inequality by adopting a whole population approach through our Better Health, Better Lives programme of work.

Our Council Plan sets out how we will build a better future, supporting children and young people to achieve their full potential, helping children and young people from all backgrounds to lead long, happy and productive lives.

Governance

Core to our understanding and oversight of progress on the WSOA is a robust governance structure. Governance of the programme is the framework of authority and accountability that defines and controls the outputs, outcomes and benefits from SEND projects, programmes and portfolios. The **SEND Strategic Partnership Board** is accountable for the delivery of SEND services. The board is chaired by the Deputy Director of Inclusion and SEND Services and co-chaired by the Lead of the Parent Carer Forum, with representation from parents and carers, Headteachers (Special, Mainstream and Further Education) and partners with delegated authority from health, education, and adult and children's social care. The agenda is planned and agreed by Education Health, Care and parents. The board will continue to oversee progress and seek assurance across this period of SEND development and improvement.

The **Bradford Wellbeing Board** provide key oversight in the Bradford District Partnership working closely with the other Strategic Delivery groups. The Health and Wellbeing Board brings together leaders from across the district including the Council, the NHS, the Police, Fire and Rescue, social housing and the Voluntary and Community sector. The Board provides strategic direction to a wide range of organisations that organise health and wellbeing services. The Board has a statutory responsibility under the Health and Social Care Act 2012 and is set up as a formal committee of Bradford Council.

This Board includes Elected Members of the Council with Portfolio responsibilities for Children's and Adult's Social Care and Education and Skills and members of the West Yorkshire Integrated Care Board Place-based Health and Care Partnership Leadership Executive, as well as the Strategic Director of Children's Services and the Chief Executive of the Council. It meets quarterly and will be provided with a report that has been considered by the SEND Strategic Board.

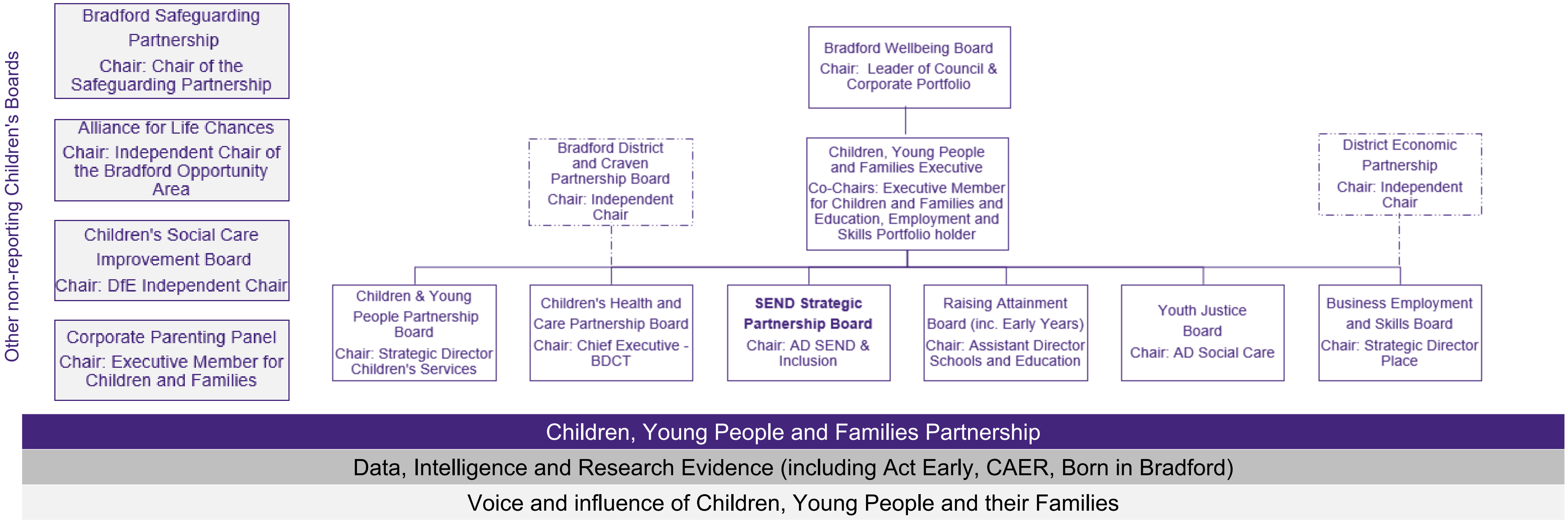
The **Children's Board** and **Health and Care Partnership Leadership Executive** (PLE) will also consider progress reports with particular attention to areas of joint priority and responsibility. Both the Bradford Wellbeing Board and PLE can confirm policy priorities and direction and influence change in the services led by its members. The Chair of the PLE will provide, by exception, any issues relating to SEND to the West Yorkshire Integration and Care Board (ICB).

The **Lead Elected Member** for Education and Skills will meet at least monthly with the Deputy Director Education and Inclusion to interrogate progress in the Written Statement of Action and explore any specific issues of concern which will be addressed at the Bradford Wellbeing Board.

Update reports to the **Cabinet of the Council** will follow a quarterly cycle for the first 12 months, supported with 6-monthly issue specific reports.

The diagram below (Figure 1) sets out the structure for reporting and monitoring of the progress of the Written Statement of Action. The **Children's Health and Care Partnership Board** (HCP) will assume responsibility for monitoring and tracking progress in relation to the health waiting times. The workstreams of the SEND Strategic Partnership Board is shown in Figure 2.

Figure 1: Children, Young People and Families Governance



Other non-reporting Children's Boards

Bradford Safeguarding Partnership
Chair: Chair of the Safeguarding Partnership

Alliance for Life Chances
Chair: Independent Chair of the Bradford Opportunity Area

Children's Social Care Improvement Board
Chair: DfE Independent Chair

Corporate Parenting Panel
Chair: Executive Member for Children and Families

Bradford Wellbeing Board
Chair: Leader of Council & Corporate Portfolio

Bradford District and Craven Partnership Board
Chair: Independent Chair

Children, Young People and Families Executive
Co-Chairs: Executive Member for Children and Families and Education, Employment and Skills Portfolio holder

District Economic Partnership
Chair: Independent Chair

Children & Young People Partnership Board
Chair: Strategic Director Children's Services

Children's Health and Care Partnership Board
Chair: Chief Executive - BDCT

SEND Strategic Partnership Board
Chair: AD SEND & Inclusion

Raising Attainment Board (inc. Early Years)
Chair: Assistant Director Schools and Education

Youth Justice Board
Chair: AD Social Care

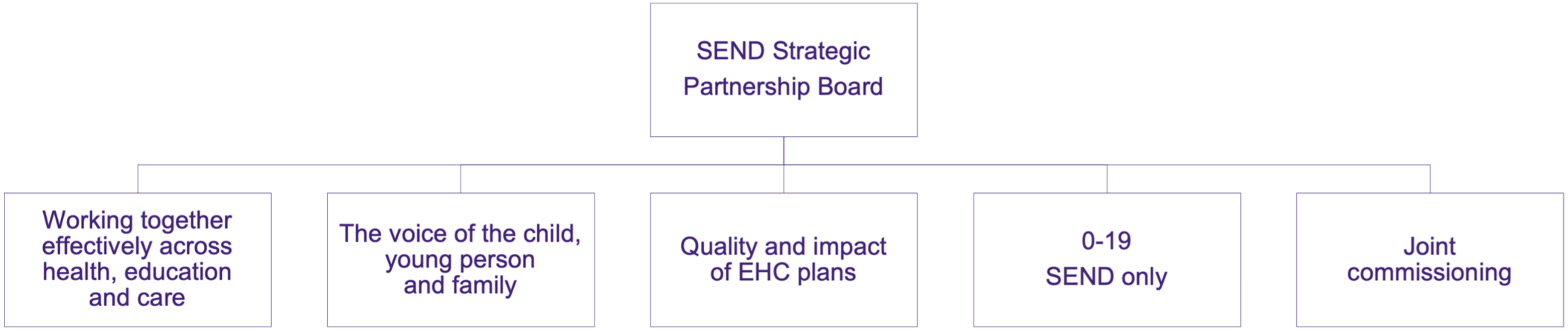
Business Employment and Skills Board
Chair: Strategic Director Place

Children, Young People and Families Partnership

Data, Intelligence and Research Evidence (including Act Early, CAER, Born in Bradford)

Voice and influence of Children, Young People and their Families

Figure 2: SEND Strategic Partnership Board Workstreams



Enablers	
Diversity	Voice of the child and family
Workforce	Child-centred

Working Well together

Partners have been working closely since the Ofsted Inspection in March 2022. Following the Inspection, weekly and monthly meetings across Education, Health and Care have contributed towards the development of the activities, projects and programmes that are taking shape to form the next stage of our improvement journey.

Senior leads have actively worked across the Local Area to reshape and implement the required changes that are needed to deliver the Written Statement of Action (WSOA). This has been a collaborative approach building on the back of our Open Houses co-production events that were completed in the Winter of 2021 prior to our inspection.

Children and young people are a priority of the whole partnership. Our shared purpose is to support children and young people with additional and complex needs, by co-producing universal and specialist services to meet the needs within the district. We have been working with a wide range of partners following the inspection to help shape and co-produce the activities contained within this Written Statement.

In line with the improvement plan set out in this WSOA, the Health and Care Partnership will continue to prioritise investments into services for children and young people to ensure the trajectories can be achieved.

We have agreed several principles to keep us working effectively together to deliver better timely outcomes for children and families between Education, Health and Social Care:

- The child/young person is at the heart of everything we do;
- The Universal Offer and Prevention and Early Intervention is our first pillar, which means encouraging and supporting individuals and families to ask for help when they need it and not when it is too late, and then ensuring that help and support is accessible when needed;
- Co-producing as a system all that we deliver, evaluate and re-design with active participation from children, parents/carers;

- Supporting children to maximise their learning, growth and development and remain happy, healthy at home, and wherever possible to be brought up and cared for within their own families;
- Adhering to the principles and behaviours set out in the single partnering agreement; and
- Sign up to a shared purpose and shared outcomes that support children and families with their physical, social, emotional mental health needs with a shared commitment to increase prevention and early intervention.

The Health and Care Partnership Leadership Executive proposed that Children and Young People will be one of our five priorities. This was endorsed by the Wellbeing Executive and SEND Strategic Partnership Board.

Local Monitoring Arrangements

The baselines established upon implementation of WSOA and targets agreed by the Action Leads will be monitored as follows:

Figure 3: Local monitoring arrangements schedule

Monthly	
Key Performance Indicators	Progress and challenge held at SEND Strategic Partnership Board Health and Care senior leadership meeting
Bi-monthly	
WSOA interim reports on progress	Targeted WSOA updates to SEND Strategic Partnership Board (exception reporting)
Quarterly	
WSOA formal reports of on progress	Council Executive Partnership Leadership Executive (PLE) Children’s Health and Care Partnership Board NHS England / Department for Education quarterly monitoring
Six-monthly	
Political oversight of WSOA	Children and Young People’s Overview and Scrutiny Committee
Annually	
Statutory responsibility	Bradford Wellbeing Board

The SEND Transformation and Compliance Team will ensure the timely production of reports that will highlight the progress of each workstream, as well as any areas of risk.

Monitoring of the WSOA

This Written Statement of Action (WSOA) will provide a framework for addressing the key issues and areas for development identified by Ofsted and the CQC in their inspection.

The WSOA is a dynamic document that will remain under constant review and therefore change over time as work is progressed. Progress against actions within each priority will be 'BRAGG' rated as follows:

Action completed and embedded:	**BLUE**
Action significantly delayed:	**RED**
Action in progress:	**AMBER**
Action on track:	**GREEN**
Action not yet started as dependent on or waiting other actions to be completed:	**GREY**

The 'BRAGG' rating above will be used as part of the monitoring process going forward which will be undertaken by the Bradford SEND Strategic Partnership Board. Milestone completion dates will be included in the WSOA as the plan is monitored, which will act as a critical measure over the next two years.

Wherever quantifiable, percentages of improvement will be recorded within the progress columns along with milestone measures and a narrative to explain the journey towards completing the actions.

Impact measures will also be quantified where appropriate, for example, percentage of parental satisfaction as the actions are delivered and become embedded.

IMPROVEMENT AREA 1

Poor communication between stakeholders across education, health and care

SRO: Niall Devlin, Assistant Director SEND and Inclusion

All stakeholders in Bradford agree that more can be done to implement stronger positive models of engagement and communication between partners in the Local Area. We are committed as partners to work as one system with a shared purpose to enhance communication between stakeholders across education, health and care. We will also co-design improvement plans in partnership with children and families to ensure measurable improvements to service outcomes and experience.

We have made substantial strides in the last 18 months, supporting the development of our SEND workstreams and co-producing our Improvement Programme for the next two years. These actions have resulted in significant positive change within services. We accept however, that further work needs to be done and we are ready to face that challenge as a system. We need to network, communicate and plan better across the local area and demonstrate greater empathy, compassion and care for all our service users. We know, as well, that we need to be clearer about how long some tasks should take before we contact our partners and families on the next steps of the pathway.

We are co-producing a new stakeholder plan that sets the metrics for how we will work together. This will agree standard timeframes to hold each other to account on and to be held to account for. These standards will be published in service level agreements. We are also committing to holding each other to a high standard of supporting families right in the first instance. We have set ourselves a target through our annual survey, where we want 65% of our parents to be happy with the service, they get from us in relation to the timeliness of our responses and the quality of our services.

The Local Area is committed to working more collaboratively with our schools. We will work to improve our involvement, to ensure that the knowledge and first-hand experience of those working closest with our children and young people with SEND is used to shape the Annual Strategic Plan – Sufficiency of Specialist places.

This will assist in ensuring that we meet the needs of all our children and young people across the district, by having the required provisions in the most needed areas of the district where possible. We will conduct an annual survey of our schools to ensure that this is the case.

We will also be refreshing our governance processes and workstreams to ensure that we get a wider level of both parental and school involvement in our workstreams to help deliver the next stage of our SEND improvement journey.

We have identified within our SEND Improvement Programme that we need to make ourselves more democratically accountable to all children and young people with SEND. We are creating a new model of participation and involvement for children across Bradford which will go live this academic year. We want to make sure their voices are heard more collectively in shaping strategic decisions, as well as committing to hearing their voices more clearly in their Education, Health and Care (EHC) plans.

The Local Area is currently in the process of refreshing the Local Offer. A project is underway to take the next step in updating this key resource. We will be working with partners to remove out of date content so that the Local Offer can be navigated more easily, monitored by quarterly auditing and published reporting. This will offer greater personalisation of content based on if you are a child or young person, parent, or professional to help you find the information you need more easily.

Table 1: Improvement Area 1 – Poor communication between stakeholders across education, health and care

Activity	Lead	Partners	Timeframe	Success/Measure	Progress	RAG
Objective 1.1 To develop an engagement and communication plan to improve communication to all stakeholders and families to ensure timely feedback and support from SEND services is provided.						
Objective 1.2 To hold engagement events with schools in relation to the sufficiency of specialist places to ensure greater awareness and input into school place planning processes.						
Objective 1.3 To deliver a new model of engagement and involvement for children and young people for SEND to increase child and young person engagement and accountability in the design and running of SEND Services.						
Objective 1.4 To widen the involvement of partners in the SEND workstreams to improve change overall to reflect new priorities in SEND services.						
Objective 1.5 To support the improvements to the Local Offer refresh to support families to find the right information at the right time.						
Objective 1.1 To develop an engagement plan for communication improvement to all stakeholders and families to ensure timely feedback and support from SEND services is provided.						
1.1.1 To form a wider representative stakeholder group to support the development of a new communication, stakeholder and engagement plan that is co-produced with partners and families that include published Service Level Agreements between education, health, social care partners and families.	Strategic Manager SEND CBMDC	• SSPB • Parents and Families Groups • All Schools across Bradford • CYP's Engagement Groups • Health Partners • Social Care • VCSE Groups	November 2022	Group formed Terms of Reference approved		🟧
1.1.2 To approve the communication stakeholder and engagement plan to	Strategic Manager SEND CBMDC	• SSPB • Parents and Families Groups	December 2022	Stakeholder Plan published		⬜

demonstrate a commitment to wider improvement for stakeholder communication with partners, families and Children.		• All Schools across Bradford • CYP's Engagement Groups.		SLA Charter approved		
1.1.3 To publish the Annual Report of parental and partner satisfaction scores of SEND Services relating to timeliness and quality of SEND services. To increase the scores from 25% in 2022 of families and partners feel they are kept informed of progress to 65% by December 2025.	Strategic Manager SEND CBMDC	• Parents and Families Groups • All Schools across Bradford • CYP's Engagement Groups	December 2023 December 2024 December 2025	35% of families / partners will feel they are kept informed by December 2023 50% by December 2024 65% by December 2025		
Objective 1.2 To hold engagement events with schools in relation to the sufficiency of specialist places to ensure greater awareness and input into school place planning processes.						
1.2.1 To hold engagement events with schools prior to the publication of the Annual Strategic Plan – Sufficiency of Specialist Places. This will ensure that schools knowledge and first-hand experience is captured and considered against our data sets / forecasts when shaping and reviewing the Strategic Plan.	Strategic Manager Sufficiency CBMDC	• School/Academies • School Representative Bodies • School Forum and sub groups	December 2022 April 2023 December 2023 April 2024	Biannual events with Schools complete		
1.2.2 To enhance awareness of the publication of the Annual	Strategic Manager Sufficiency	• Schools/Academies	September 2022 & further	70% of schools report they are		

Strategic Plan – Sufficiency of Specialist places.	CBMDC	• School Representative Bodies • School Forum and sub groups	in September 2023	satisfied they are aware of the plan of sufficiency		
Objective 1.3 To deliver a new model of engagement and participation for children and young people for SEND to increase child and young person engagement and accountability in the design and running of SEND Services.						
1.3.1 To finalise the model of student and pupil engagement, and to approve the model of democracy for participation for children with SEND in Bradford.	SEND Transformation Manager CBMDC	• Coproduction and Engagement Workstream Members • School representative Bodies • SEND Young Ambassadors	December 2022	Model agreed and approved by SEND Partnership Board		🟧
1.3.2 To commence the Children & Young People's democratic and participation function across Bradford schools	SEND Transformation Manager CBMDC	• Coproduction and Engagement Workstream Members • School representative Bodies • SEND Young Ambassadors	March 2023	New model launched in 2022/23 Academic Year		🟧
Objective 1.4 To widen the involvement of partners in the SEND workstreams to improve change overall to reflect new priorities in SEND services.						
1.4 .1 To revise SEND governance arrangements increasing parental and school participation reflecting the new work areas identified within the SEND Improvement Programmes 2022- 2024	SEND Transformation Manager CBMDC	• SSPB Members • Previous Workstream Members • SEND Ambassadors • School Forum Reps	October 2022	New Governance Approved		🟧

Objective 1.5 To support the improvements to the Local Offer refresh to support families to find the right information at the right time						
1.5.1 To review and amend or remove out of date content within the Local Offer.	Local Offer Lead CBMDC	• All SEND Workstreams • PFBA / Aware • School Forum Members	October 2022 December 2022 April 2023 (Ongoing biannually) December 2023 (ongoing quarterly)	Complete Data quality audit All Local Offer pages to have named owner by Dec22 Bi-annual review of dip-sample of Local Offer pages to be complete 95% of Local Offer pages which are audited are up to date		🟧
1.5.2 To launch the new Local Offer website, to support families to find the right information at the right time	Local Offer Lead CBMDC	• All SEND Workstreams • PFBA / Aware	November 2023	New Local Offer Launched		🟧

How will we know that what we are doing is making a difference?

Outcome Indicators

1.1 Within our EHC Annual Survey, by 2025 65% of our families & Partners are happy with the timeliness and quality of services that they receive

1.1 That quarterly dip sampling of cases meets our revised SLAs with children and families about timeliness of response from the SEND Integrated Assessment Teams

1.2 That 70% of Schools in the Review Survey report on improved levels of engagement with the Local Authority on School Place Planning by 2024

1.3 That the new model of democracy and engagement is launched in 2022/2023 Academic Year

1.4 Revised Governance Arrangements agreed by October 2022

1.5 That 95% of Services reported within the Local Offer audit have up to date service information

1.5 That the Updated Local Offer goes live by September 2023

Improvement Area 1 Impact Statement

The table below sets out what children, families and partners can expect, as a result of the actions set out in this WSOA.

WSOA 1 Objectives	How will this make a difference to children and families?	An example in practice
1.1 To develop a stakeholder and engagement plan for communication improvement to all stakeholders and families to ensure timelier feedback and support from SEND services is provided.	Families and professionals will have a published group of service level agreements so they know what and when they can expect updates on their case. This will clarify the timeframes for families and professionals about queries, applications and updates on matters relating to next steps which are clear. Professional letters are reviewed and made more personal in providing core updates. Greater preferencing of parental wishes is considered and then acted upon in a published timeframe.	A family have emailed the Integrated Assessment inbox for an update on their child's draft EHC Plan. They receive an email saying that all queries relating to draft plans will be responded to within 5 days either by phone or email. They ask if they can be called back on an update as opposed to receiving an email. They receive a phone call from their EHC Officer 4 days later to talk through Section A of the child's plan as there are some areas that need further information to be placed in there.
1.2 To hold engagement events with schools prior to the publication of the Annual Strategic Plan – Sufficiency of Specialist Places. This will ensure that schools knowledge and first-hand experience is captured and considered against our data sets/forecasts when shaping and reviewing the Strategic Plan.	Schools will be sighted on sufficiency plans so they understand what places are being built and when and to test though a survey to see if they are happy with the engagement and with the forward plan for places.	The Strategic Plan is shared with Schools Forum showing detailed place allocations for the next two years showing the type of places and locations we are expanding and why. Schools are supported to share their thoughts on the style and concepts being presented to help shape future strategies, plans and consultations for new school places.

1.3 To deliver a new model of engagement and participation for children and young people for SEND to increase child and young person engagement and accountability in the design and running of SEND Services.	Children are given an opportunity to co-produce the services of the future and to be given more opportunities to be involved in the democratic and co-productive elements more widely of services that support them.	A new SEND Youth Council meets termly to help design, challenge and scrutinise new services for short breaks that will take place in their schools. Children design and vote on their favourite proposals and decide to include more active sport and play, and new reading based support to help them.
1.4 To widen the involvement of partners in the SEND workstreams to improve change overall to reflect new priorities in SEND services.	More parental engagement is put into the workstreams to support, coproduce and challenge the workstream progress to support further benefits to children and families.	20% of the workstream core members are made up of parents to reflect greater parental involvement in the progress and decision making. More parental views are captured organically as part of our improvement works so that greater input is shared more regularly and provides greater balance to proposals and work being done.
1.5 To support the improvements to the Local Offer refresh to support families to find the right information at the right time.	The new Local Offer will not contain out of date information and acts as personalised resource to help parents, carers, professionals and young people find what they need easily about services.	The Local Offer contains three front doors that provider greater personalisation, to children and young people, parent's professionals. This allows them to move towards pages and services that provide greater resonance to them and give them what they need quicker and with greater personalisation to their needs.

IMPROVEMENT AREA 2

The variable quality of EHC plans, including plans which do not fully describe the provision that children and young people with SEND need.

SRO: Niall Devlin, Assistant Director SEND and Inclusion

Within our SEND improvement journey, we plan to further improve the timeliness of reissuing Education, Health and Care (EHC) plans following annual reviews. We are proud of our efforts to support the improvements we have made over the last two years, where seven families out of ten now get their EHC plan within twenty weeks.

We are now embarking on the next phase to ensure that Annual Reviews of our EHC plans are done within compliant time limits. We will be prioritising our efforts to ensure updated EHC plans are reissued to families within agreed statutory required time limits of an annual review taking place. This will ensure we are in line with the findings of the recent judicial review and within the proposals outlined within the SEND Review: Right Support, Right Place, Right Time Government consultation on the SEND and alternative provision system in England. We are recruiting a new Annual Review Team to help us with these tasks to support families that will be in place by early 2023.

A thematic review of our EHC Plans has found further work is required to strengthen the quality of contributions from statutory partners and to ensure that these are accurately reflected in the final EHCP. Our priority is to ensure plans reflect the identified needs of children in our District. We know that accurate and meaningful contributions to specify health and social care needs is not always reflected in our plans, particularly where a child is supported with a child protection plan or where they have been brought into care.

The Local Area agree with Ofsted that more needs to be done to strengthen the inclusion of meaningful Preparation for Adulthood outcomes in our EHC Plans on a more consistent basis. We also know that out-of-date Key Stage of Education outcomes are too often found in our plans for children. This means in practice that we cannot always fully understand if children are making the expected progress we want for them.

Working with our Improvement Partner Warrington Council, we know that we need to measure our improvement in these areas through a new Quality Assurance Framework that will become integral to how we monitor quality and will replace existing quality monitoring arrangements.

The Quality Assurance Framework aims to provide a range of mechanisms to help set direction, support delivery, manage risk, monitor and review practice and outcomes for children and young people.

Bradford is also currently on an improvement journey to embed its new SEND performance framework (Vital Signs). This will help us provide further clarity and understanding on the quality and timeliness of activities relating to our EHC Processes. We are committed as a partnership to share accurate and timely progress with others, to ensure greater confidence that our overall improvement work is delivering the outcomes we want for children and families.

Table 2: Improvement Area 2 – The variable quality of EHC plans, including plans which do not fully describe the provision that children and young people with SEND need.

Activity	Lead	Partners	Timeframe	Success/Measure	Progress	RAG
Objective 2.1 All Annual Reviews are consistently re-issued within the required time limits to ensure all children receive appropriate support in line with their needs.						
Objective 2.2 To improve the meaningful and accurate contribution of health and social care to EHC Plans to ensure the correct contributions from professionals allowing children and families to access the right services to support their child.						
Objective 2.3 To ensure PFA Outcomes are stated in all EHC Plans from Year 9 in all annual reviews, so that a clear pathway is identified to support a young person prepare for adulthood.						
Objective 2.4 To ensure that EHC plans have meaningful outcomes that are relevant to a child's journey and relate to their current Key Stage of Education so that provisions meet a child's needs.						
Objective 2.5 To improve the number of plans that are audited that meet the needs of children as set out in the Quality Assurance Framework.						
Objective 2.1 All Annual Reviews are consistently re-issued within the required time limits to ensure all children receive appropriate support in line with their needs.						
2.1.1 To recruit the new Annual Review Team within Education and Learning to improve the timeliness of amended EHC plans being issued to families and schools.	Strategic Manager SEND CBMDC	• Children and Young People's Engagement Groups. • Health and Social Care Partners	February 2023	8 FTE Annual Review Officers recruited		🟩
2.1.2 To improve the current timeliness of EHC plans being reissued following an Annual Review.	Strategic Manager SEND CBDMC	• All Schools across Bradford • Children and Young People's Engagement Groups. • Statutory Health Partners • Social Care Leaders	December 2022 January 2024 (70%)	Launch of Annual Review Portal By January 2024, 70% of all EHC Plans will be re-issued in line with statutory required		🟧

			January 2025 (80%)	time limits following an Annual Review. By January 2025, 80% of all EHC Plans will be re-issued in line with statutory required time limits following an Annual Review.		🟧
Objective 2.2 To improve the meaningful and accurate contribution of health and social care to EHC Plans to ensure the correct contributions from professionals allowing children and families to access the right services to support their child.						
2.2.1 To improve the contribution of Social Care to EHC Plans to ensure social care advice and support is identified and recorded accurately within plans.	DSCO Social Care Bradford Children's Trust	SEND Services Social Care Leaders	January 2024 (65%) January 2025 (80%)	By January 2024, 65% of all EHC Plans will have up to date Social Care Advice. By January 2025, 80% of Plans will have up to date Social Care advice.		🟧
2.2.2 To improve the contribution of Health to EHC Plans to ensure health advice and support is identified and recorded accurately within plans.	Designated Clinical Officer Health Professionals*	SEND Services NHS Trust Leadership Statutory Health Partners / DCO	January 2024 (65%) January 2025 (80%)	By January 2024, 65% of Plans will have up to date Health Advice. By January 2025, 80% Plans will have up to date Health advice.		🟧

Objective 2.3 To ensure PFA Outcomes are stated in all EHC Plans from Year 9 in all annual reviews, so that a clear pathway is identified to support a young person prepare for adulthood.						
2.3.1 To ensure PFA outcomes are correctly recorded in EHC Plans from Year 9 to ensure greater consistency to support PFA planning in EHC plans in the Local Area. (Baseline currently 30%)	Strategic Manager SEND CBMDC	• PFA Workstream Members • School representative Bodies • SEND Young Ambassadors	January 2024 (75%) January 2025 (80%)	By January 2024, 75% of all EHC plans with have up to date PFA Outcomes recorded. By January 2025, 80% of all EHC plans with have up to date PFA Outcomes recorded.		🟧
Objective 2.4 To ensure that EHC plans have meaningful outcomes that are relevant to a child's journey and relate to their current Key Stage of Education so that provisions meet a child's needs.						
2.4 To ensure EHC plans have appropriate educational Key Stage outcomes recorded to ensure provisions meet the needs of children.	SEND Team Manager CBMDC	• Coproduction and Engagement Workstream Members • School representative Bodies • SEND Young Ambassadors	January 2024 (75%) January 2025 (80%)	By January 2024, 75% of all EHC plans with have up to date appropriate Key Stage outcomes recorded. By January 2025, 80% of all EHC plans with have up to date appropriate Key Stage outcomes recorded.		🟧

Objective 2.5 To improve the number of plans that are audited meet the needs of children as set out in the Quality Assurance Framework.						
2.5.1 To introduce the new Quality Assurance Framework working with our DFE Improvement Partner.	Strategic Manager SEND CBMDC	• SSPB Board Members • Integrated Assessment Board Members • SLI Partner Warrington Council • SENDCO Network	November 2022	New QA Framework Launched		🟩
2.5.2 To launch updated performance framework to support oversight of EHC Plan improvements.	Strategic Manager SEND CBDMC	• SSPB Board Members • Integrated Assessment Board Members • SLI Partner Warrington BC • SENDCO Network	November 2022	New Performance Framework Launched		🟩
2.5.3 To improve the overall percentage of EHC plans being independently assessed under the QA framework as meeting the needs of children.	Strategic Manager SEND CBDMC	• SSPB Board Members • Integrated Assessment Board Members • SLI Partner Warrington BC • SENDCO Network	January 2024 (70%) January 2025 (80%)	By January 2024, 70% of all EHC plans will be independently considered to be deemed, to be sufficient to meet needs. By January 2025, 80% of all EHC plans will be independently considered to be deemed, to be sufficient to meet needs.		🟧

How will we know that what we are doing is making a difference?

Outcome Indicators	2.1	Improve the timeliness of the re-issuing of EHC Plans following an Annual Review within agreed statutory time limits to 70% in 2024 and 80% in 2025
	2.2	To improve the contribution of Social Care to EHC plans to 65% in 2024 and to 80% in 2025
	2.2	To improve the contribution of health advice to EHC Plans to 65% in 2024 and 80% by 2025
	2.3	To improve the numbers of Year 9 pupils with PFA Outcomes recorded in their EHC Plans to 75% in 2024 and to 80% by 2025
	2.4	To improve the numbers of pupils with appropriate Key Stage outcomes recorded in their EHC Plans to 75% in 2024 and to 80% by 2025
	2.5	To increase the numbers of EHC plans found to be sufficient, to meet needs through independent audit to 70% in 2024 and 80%% in 2025

Improvement Area 2 Impact Statement

The table below sets out what children, families and partners can expect, as a result of the actions set out in this WSOA.

WSOA 2 Objectives	How will this make a difference to children and families?	An example in practice
2.1 All Annual Reviews are consistently re-issued within the required time limits to ensure all children receive appropriate support in line with their needs.	Families and schools receive up to date plans that clearly articulate any material changes to an EHC plan that set out the support and provisions that are reflective of a child's needs and demonstrate their lived experiences.	Schools receive their updated paperwork back in a timely manner setting out what change in support will now be provided to a child / young person to meet their outcomes. This can include a change of resource allocation in terms of 1:2:1 support that is needed now that further needs have been identified in the annual review. A change of circumstances to access health services has also been found that opens access to health provisions that without their input into the EHC Plan would not be accessed by a family or child.
2.2 To improve the meaningful and accurate contribution of health and social care to EHC Plans to ensure the correct contributions from professionals allowing children and families to access the right services to support their child.	Families receive plain English descriptions of the support they are going to receive from social care and health that is practical in nature and focuses on supporting any health conditions and social care needs a child may have. This helps to support families to understand how and where they can access services that support their child's health and social care needs.	Health example in a plan: Elena (9 years old) will have a physiotherapy programme developed by her therapist for use in school in advance of the start of Year 5. Within the first week of Elena starting Year 5, school staff will be trained in the programme by a member of the therapy team. The programme will subsequently be reviewed at the beginning of every half term. Social Work example in a plan- James (10 years old) will have a place reserved at the local specialist holiday scheme for young children with autistic spectrum disorder. He will be able to attend for six half day sessions of his parents choosing during each school holiday period. This is funded by the Children with Disabilities team.
2.3 To ensure PFA Outcomes are stated in all EHC Plans from Year 9 in all annual reviews, so that a clear pathway is identified to support	Preparation for Adulthood outcomes are included as early as possible to support a child and young person meet their potential. That support and services are wrapped around these	At the Annual Review for Hassan in Year 8, early dialogue is formed at the review meeting setting out personalised inputs into his plan that consider his cognition and learning, communication & interaction, SEMH and his sensory, medical and physical needs.

a young person prepare for adulthood.	objectives in the plan to help a young person transition into the most suitable education, employment or training opportunities.	These are included in his new plan and form the basis of his PFA journey into Year 9 and above. They form key drivers in terms of his future schooling arrangements, his curricula and his work experience opportunities though Year 9 and beyond.
2.4 To ensure that EHC plans have meaningful outcomes that are relevant to a child's journey and relate to their current Key Stage of Education so that provisions meet a child's needs.	Families have the most appropriate Key Stage outcomes recorded in the child's plan so that progress can be tracked to see where a child is meeting their stated objectives that is reflective of a young person's journey through education. This will support families to better understand progress and to support and challenge the quality of services that a family is receiving where appropriate.	As part of the Annual Review for Hannah who is in Year 3, a review of her KS1 outcomes considered the progress she has made in Years 1 and 2 in her school since she received her EHC Plan in Reception. Professionals who know Hannah, consider her aspirations in Section A of her EHC plan and provide new outcomes that are smart and relevant to her lived experience. These form her updated plan that is then reviewed annually to review the progress against her new outcome measures.
2.5 To improve the number of plans that are audited that meet the needs of children as set out in the Quality Assurance Framework.	Plans will have greater value and meaning to both parents and professionals due to a child's plan accurately reflecting their journey and what support they need moving forward. This will help inform the size and shape of services that are needed to meet sufficiency needs of children individually and as a whole.	A thematic review of all children on the Edge of Care in 2023 found that 75% of all plans accurately reflect the child's journey and their needs had been identified. There were however some areas of wider thematic growth that is required about setting out PFA outcomes in children in Year 9 and above. A new Project is approved and commissioned to ensure all plans in this cohort reflect this requirement and the SEND Strategic Partnership Board request an update 6 months later on progress to address this training and operational matter. This is completed and on re-review 90% of plans for children on the edge of care have meaningful PFA outcomes embedded in them.

IMPROVEMENT AREA 3

The inconsistent delivery of the 0 to 19 health visiting, school nursing and specialist nursing services.

SRO: Sarah Muckle, Director of Public Health

Our 0-19 Services are the foundations upon which all child health services are built, to support the early identification of children who have SEND and additional needs.

The Local Area is committed to having the right foundations in place, to ensure we can support the wider health and care system to identify our children’s needs earlier and in a more consistent manner. This will help us to improve outcomes for children and their families, to provide them with the right support, in the right place, at the right time.

The Council has identified over £1m of additional in-year investment for the 0-19 service. This will become recurrent from April 2023. The Council and Bradford District Care Foundation Trust (BDCFT) are working together to use the additional funds to improve the Health Visiting and School Nursing Service, focusing on the experience of babies, children, young people and families. We are committed to ensuring that we improve face-to-face antenatal contacts with prospective parents. This will help identify needs early, including before birth where appropriate so that babies and children who are vulnerable or who have complex needs are identified and supported early.

The service offer will also ensure that developmental reviews for children aged between two and two and a half years are completed consistently, allowing for the greater early identification of additional needs for the child population of our District. Work to increase the numbers of professionals in the School Nursing Service is also taking place.

Council and health colleagues will work together to ensure that training offered by specialist services is available for professionals and parent / carers to ensure that children and young people and their families have consistent support within the setting they are attending.

We are committing to creating new screening pathways, to ensure that all children across the District are screened for hearing and visual impairments so that the 0-19 service and wider system can recognise and provide support to children with emerging sensory impairments.

Engagement and consultation on children’s 0-19 services has taken place with families, schools, Voluntary Community Social Enterprise (VCSE) organisations, and partners, to inform development and innovation within the 0-19 contract to improve the experience of babies, children, young people and families.

Partners will work together to review 0-19 and specialist nursing services to ensure that specialist provision dovetails seamlessly with the 0-19 service offer. This will include a review of: the 0-19 service offer; School Nursing Special Needs; mainstream specialist school nursing; community children’s nursing; continuing care and children looked after services. This will ensure that the identification of additional needs for vulnerable and complex children takes place as early as possible and that, once identified, needs are supported seamlessly by all relevant agencies.

Bradford is one of 75 areas in the country which has received Start for Life funding. The Council’s Early Help teams are working closely with a range of partners to use this funding to ensure that babies, children and families have access to trained professionals from a wide range of services in family hubs. This will improve early identification and addressing of additional needs across Bradford in community settings, and improve the experience for families, especially for children and young people with SEND.

Table 3: Improvement Area 3 – The inconsistent delivery of the 0-19 Health Visiting, School Nursing and Specialist Nursing Service

Activity	Lead	Partners	Timeframe	Success/Measure	Progress	RAG
Objective 3.1 To improve the consistency of the Health Visiting, School Nursing and Specialist School Nursing services so that families, babies and children have additional needs identified and addressed early. Objective 3.2 To improve delivery of Vision and Audiology screening, so that reception-aged children have hearing and visual impairment identified and addressed early. Objective 3.3 To make sure that training by the specialist nursing teams is delivered consistently to partners, so that children have their needs understood and met by people within the settings they are attending. Objective 3.4 To ensure that children and young people's additional needs are identified effectively by Early Help practitioners and in family hubs so that babies, children and families receive the help they need more consistently.						
Objective 3.1 To improve the consistency of the Health Visiting, School Nursing and Specialist School Nursing services so that families, babies and children have additional needs identified and addressed early						
3.1.1 BDCFT to implement plans to establish new teams and ways of working within the Health Visiting service which streamline services and improve the proportion of women receiving routine antenatal contacts (baseline 2021/22 = 34.3%)	General Manager Community Services BDCFT	Senior Public Health specialist CBMDC Babies, children and families	September 2022 December 2022 September 2023	35% of parents receive an antenatal visit 40% of parents receive an antenatal visit 55% of parents receive an antenatal visit	KPI target 55%	🟨
3.1.2 BDCFT to implement their plan to establish new teams and ways of working within the Health Visiting service which streamline services and	General Manager Community Services BDCFT	Senior Public Health specialist CBMDC Babies, children and families	September 2022	90% of children receive a 2-year check with ASQ3 assessment by age 30 months	KPI target is 90%	🟨

improve the proportion of children receiving the routine 2-2.5-year check/ ASQ (baseline 2021/22 = 54.7%).			December 2022 March 2023 December 2023	92% of children receive a 2-year check with ASQ3 assessment by age 30 months 92% of children receive a 2-year check with ASQ3 assessment by age 30months 95% of children receive a 2-year check with ASQ3 assessment by age 30 months	KPI target is 95%	🟨
3.1.3 Key stakeholders review and develop core and specialist pathways between 0-19 and Specialist services to ensure seamless and consistent processes for CYP and families	General Manager Community Services BDCFT	Consultant in Public Health CBMDC BDC HCP Families and children	January 2023 November 2023 March 2024	Pathways identified for development Pathways developed Pathways active		⬜
Objective 3.2 To improve delivery of Vision and Audiology screening, so that reception-aged children have hearing and visual impairment identified and addressed early						
3.2.1 BDCFT to deliver audiology screening at school entry so that hearing impairment is identified and addressed early.	General Manager Community Services BDCFT	Senior Public Health specialist CBMDC Babies, children and families	December 2022	40% of reception children screened for AI	Schools run on an academic year so performance is cumulative September – July	🟨

(Baseline 2019/20 = 66.4%)			March 2023 July 2023	70% of reception children screened for AI 100% of eligible reception children offered VI screening, with 90% of reception children screened for AI		🟨
3.2.2 Develop and implement a consistent, effective vision screening pathway for children on school entry	Senior Public Health specialist CBMDC	Consultant in Public Health, CBMDC BDCFT BTHFT Children and families	January 2023 July 2023	Plans in place 100% of eligible reception children offered VI screening, with 93% taking this up	Schools run on an academic year so performance is cumulative September – July.	🟨
Objective 3.3 To make sure that training by the specialist nursing teams is delivered consistently to partners, so that children have their needs understood and met by people within the settings they are attending.						
3.3.1 Key stakeholders review and enhance the current training offer to schools, parents and carers, and other professionals/ services to ensure that health needs of CYP are met consistently and that access to training doesn't delay access to care and/or support	Senior Head of Integration and Change, (Women and Children) BDC HCP	BDCFT, BTHFT Integration & change team Personalised commissioning team CBMDC (social care)	December 2022 September 2023 December 2023	Training audit to identify priority areas Published training offer 75% of those that take the training offer up report a positive impact		

Objective 3.4 To ensure that children and young people’s additional needs are identified effectively by Early Help practitioners and in family hubs so that babies, children and families receive the help they need more consistently						
3.4.1 Ensure that practitioners within family hubs and the in-development Start for Life model have training to ensure that children’s SEND needs are consistently identified and responded to early in these settings.	Prevention and Early Help service manager CBMDC	Public health, CBMDC Children and families Health partners VCS agencies as appropriate for local communities	December 2022 July 2023	SEND training offer for family hub staff developed 75% of Prevention and Early Help staff in family hubs are trained to the appropriate level		▨
3.4.2 Develop and implement plans for family hubs and the Start for Life programme which co-locate a wide range of services, so that babies, children, young people and families have access to practitioners through family hubs who can identify and respond to additional needs.	Prevention and Early Help service manager CBMDC	Public Health, CBMDC Children and families Health partners VCS agencies as appropriate for local communities	December 2022 December 2023	Start for life plan includes colocation of a wide range of partners and services including 0-19 service 60% of people are happy with the range and quality of the services provided within family hubs		🟨

How will we know that what we are doing is making a difference?

Outcome Indicators

3.1.1 That 55% of parents receive an antenatal visit by September 2023

3.1.2 That 95% of children receive a 2 year check using ASQ3 by age 30 months, by December 2023

3.1.3 Pathways move from developed to active by March 2024

3.2.1 That 90% of children are screened for AI in their first year of school by July 2023

3.2.2 That 93% of children are screened for VI in their first year of school by July 2023

3.3.1 75% of partners/parent carers who take the training offer up report a positive impact by December 2023

3.4.1 75% of staff in family hubs are trained to the appropriate level by July 2023

3.4.2 60% of people are happy with the range and quality of the services provided within family hubs by December 2023

Improvement Area 3 Impact Statement

The table below sets out what children, families and partners can expect, as a result of the actions set out in this WSOA.

WSOA 3 Objectives	How will this make a difference to children and families?	An example in practice
3.1 To improve the consistency of the Health Visiting, School Nursing and Specialist School Nursing services so that families, babies and children have additional needs identified and addressed early.	More families will consistently get an antenatal visit pre-birth to provide information, advice and guidance to prospective parents. Families with additional needs will also be identified early and supported and/ or referred to other appropriate services. Health visitors post-birth will continue to support parents and more 2 and half year-old checks will be completed on time, providing improved opportunities for the early identification of needs so that parents are supported sooner where needed. Families will have a better experience (feeling involved and cared for) when liaising with school nursing, specialist school nursing and other specialist services as consistent pathways will enable smooth transitions and closer working between different services.	Josh attending a local nursery has been identified by the EYFS co-ordinator to potentially have a language delay. The 0-19 service assess Josh at 29 months and agrees with the findings of the EYFS setting. The Health Visiting team refers Josh for additional support to help develop his speech and language and a bespoke package of support is agreed for him following the 2 and half year old check.
3.2 To improve delivery of Vision and Audiology screening, so that reception-aged children have hearing and visual impairment identified and addressed early	Children across the Bradford district will receive the hearing and vision screening checks when they are in the reception class. This will help to identify children who may have a hearing or visual impairment earlier in their childhood, providing greater opportunity to support these groups of children meet their potential.	Alissa is a young girl in reception has hearing loss that is moderate in both ears. She is screened in her school as part of the Healthy Child Programme and is referred to Audiology for further support following the hearing tests. She is seen by an audiologist and provided with hearing aids that support her in class. Alissa is also provided with further support in her mainstream school so she doesn’t miss important information that impacts on her interactions with her peers in school.

		This helps her substantially and allows her to take part in her school activities. Advice provided to her parents also allows her to interact with her family better allowing her to fully partake in family plans and activities.
3.3 To make sure that training by the specialist nursing teams is delivered consistently to partners, so that children have their needs understood and met by people within the settings they are attending	The specialist nursing services provide training to a wide range of schools, services and parent / carers. Trainers provide evidence based information and guidance that help schools and other partner agencies support the child/young person's needs.	The Children's Community Nursing team provides training to schools and staff in short breaks settings in the management and care of enteral feeding. Schools and staff working in short breaks feel confident in supporting children who are enterally fed, meaning that children can attend school and short break settings.
3.4 To ensure that children and young people's additional needs are identified effectively by early help practitioners so that babies, children and families receive the help they need more consistently	Families who go to the newly re-launched family hubs are supported by a range of professionals and early help staff. All practitioners will have the skills to assess and support families appropriately and sign post where appropriate. They identify a range of potential additional needs in children and refer these to the most appropriate pathways in the Early Years stage before the children are of school age. Families' needs are identified early and appropriate support will be offered. Family will report they have good support.	A family of two siblings who go to the hub are having difficulty with sleep feeding and toileting. The children are new to the country and English is not a first language for the parents. The Hub reviews the presenting factors make referrals with the parents' consent to a range of services to support the children. This proves important as because of this intervention the children are found to require support through the dietetics and paediatrics service and have undiagnosed autoimmune diseases.

IMPROVEMENT AREA 4

Children and young people wait too long for assessments, treatment and diagnosis. There is insufficient support for children and young people with SEND who are waiting for provision, services, diagnosis or equipment.

SRO: Ali Jan Haider, Director of Integration and Change

We recognise that children and young people wait too long for assessments, treatment and diagnosis across key health services and that there is a lack of effective, timely support offered while children and young people are waiting for services. This is leading to some families struggling to cope, which can negatively impact on their health and wellbeing. These services include the child and adolescent mental health service (CAMHS), speech and language therapy (SaLT), diagnostic pathways for ASD (autism spectrum disorders) and ADHD (attention deficit hyperactivity disorder), annual health checks for children and young people with a Learning Disability and initial and review health assessments for children and young people in care. Waiting too long for assessments limits the opportunity to provide services for those children and young people who require more specialist support; this can then have an adverse effect on their educational and life outcomes.

Significant work has already been undertaken to improve assessment pathways; this includes developing a new GP led model for initial health assessments and additional investment in review health assessments. £1.7m non-recurrent funding and £700,000 recurrent funding has been invested to reduce waits for ASD and ADHD assessments. This reduced the average waiting times for children’s autism assessments from 50 weeks in March 2021 to 27 weeks in March 2022.

Work has commenced to review the service pathway and model for Speech and Language Therapy services, with the aim of embedding early identification and intervention at the heart of the model and ensuring specialist services are targeted at those children and young people with the most complex needs. The Centre for Mental Health reviewed local Emotional Health and Wellbeing services for children and young people in 2020 and an ambitious programme of improvement was developed in response to this under our Act as One Programme approach. We recognise that more needs to be done to further reduce waiting times for assessments and treatment and we are committed to making this happen.

We recognise that as a local area we have been slow to identify and support children and young people with SEND who have intensive and/or complex needs. This includes the implementation of a dynamic support register. Action has been taken to address this and health partners have worked with key stakeholders to develop a dynamic support co-ordination approach. This identifies and supports children and young people with a Learning Disability and/or Autism and/or a Mental Health condition or a Social Emotional Mental Health (SEMH) need who are at risk of admission to Specialist In-Patient Units or irretrievable and multiple Placement Breakdown.

The inclusion of children and young people with mental health support and SEMH needs in the dynamic support approach is being recognised as trail blazing. The approach is to launch in Autumn 2022 and aims to reduce in-patient admission to specialist hospitals and to ensure effective support is available in communities; enabling children and young people with the most complex needs to remain supported at, or near to, home.

The provision and co-ordination of children's specialist equipment, such as wheelchairs is poor and children with SEND do not receive specialist equipment in a timely manner. A senior commissioning manager has commenced a review of the current pathways and is working with services and equipment providers to improve the timeliness of equipment provision to children and young people with SEND.

We know we must do more to provide support for children and young people while they are waiting for assessment. We have developed innovative approaches such a funding the Voluntary Community Social Enterprise "BEAT" service to support children and young people and their families whilst they are waiting for Autism or ADHD assessment. However, support whilst waiting for assessment is currently limited. Of particular focus is developing early intervention services and support services for children who may have Speech Communication or Language difficulties, Autism or a Learning Disability.

Table 4: Improvement Area 4 – Children and young people wait too long for assessments, treatment and diagnosis. There is insufficient support for children and young people with SEND who are waiting for provision, services, diagnosis or equipment.

Activity	Lead	Partners	Timeframe	Success/Measure	Progress	RAG
Objective 4.1 To reduce waiting times for autism/ADHD assessment and strengthen the support offer whilst waiting for assessment						
Objective 4.2 To reduce waiting times for CAMHS services and strengthen the support offer whilst waiting for assessment and treatment						
Objective 4.3 To reduce waiting times for SaLT assessment and strengthen the support offer whilst waiting for assessment and treatment						
Objective 4.4 To improve timeliness of provision of specialist equipment and wheelchairs for CYP with SEND						
Objective 4.5 To ensure dynamic support co-ordination approach is embedded for CYP with LD/ND/MH and or SEMH						
Objective 4.6 To increase the uptake of Annual Health Reviews for CYP aged 14-25						
Objective 4.7 To improve the timeliness of Initial Health Assessments and Review Health Assessments for children in care						
4.1 Reduce waiting times for autism/ADHD assessment and strengthen the support offer whilst waiting for assessment.						
4.1.1 Review the service offer across all key stakeholders to understand the current service pathway and provision for Autism and ADHD.	Senior Head of Integration & Change CYP LD/ND BDC HCP	• CYP/Parents/Carers • Education/Ed Psych • Communities • 0-19 services • Prevention/Early Help services • Social Care • Specialist Nursing • Primary Care • Early Years • VCSE • Public Health	March 2023	Current service pathway is mapped and all key stakeholders are aware of current service offer		🟨

4.1.2 Review, define and communicate the referral criteria for Autism and ADHD assessment to all key stakeholders to ensure that only CYP who need assessment are referred.	Service Manager for Autism/ADHD waiting lists	• CYP/Parents/Carers • Education/Ed Psych • Communities • 0-19 services • Prevention/Early Help services • Social Care • Specialist Nursing • Primary Care • Early Years • VCSE • Public Health	March 2023	Referral criteria is reviewed and signed off and is shared with key stakeholders including children, young people and families		
4.1.3 Using a co-production approach improve service provision, including review of offer across the self-help, universal and early intervention offer for Autism and ADHD to ensure support is available whilst CYP wait for assessment and to ensure that CYP and families receive advice and support as early as possible to reduce the need referral to specialist services.	Senior Head of Integration & Change CYP LD/ND BDC HCP	• CYP/Parents/Carers • Education/Ed Psych • Communities • Provider services • 0-19 services • Prevention/Early Help • Social Care • Specialist Nursing • Primary Care • Public Health	March 2023 September 2023 March 2023	Self-help, Universal and Early Help pathway is agreed Evidence of the delivery of the support pathway for Autism/ADHD from self-help, universal offer and early help services Evidence of signposting to support whilst waiting for Autism/ADHD assessment		

4.2 Reduce waiting times for CAMHS services and strengthen support offer whilst waiting for assessment and treatment.						
4.2.1 Review the service offer across all key stakeholders to understand the current service pathway and provision for CYP who require support with their Mental Health.	Senior Head of Integration & Change Mental Health services BDC HCP	• 0-19/Mental Health Support Team (MHST)/CAMHS • Social Care • Provider services • Prevention/Early Help • Education/ Ed Psych • CYP/Families • Primary Care/VCSE • Communities	March 2023	Current service pathway is mapped and all key stakeholders are aware of current service offer		
4.2.2 Review, define and communicate the referral criteria for CAMHS services to all key stakeholders to ensure that only CYP who need specialist CAMHS services are referred for assessment and treatment.	Service Manager CAMHS BDCFT	• 0-19/MHST/CAMHS • Social Care • Provider services • Prevention/Early Help • Education/ Ed Psych • CYP/Families • Primary Care/VCSE • Communities	March 2023	Referral criteria is reviewed and signed off and is shared with key stakeholders including children, young people and families		🟨
4.2.3 Using a co-production approach improve service provision across the self-help, universal and early intervention offer for CYP mental health services to ensure support is available whilst CYP wait for	Senior Head of Integration & Change Mental Health services BDC HCP	• 0-19/MHST/CAMHS • Social Care • Provider services • Prevention/Early Help • Education/ Ed Psych • CYP/Families	March 2023 September 2023	Self-help, Universal and Early Help pathway is agreed. Evidence of delivery of support for CYP with SEMH needs from Self-		🟨

CAMHS assessment and to ensure that CYP and families receive advice and support as early as possible to reduce the need for referral to specialist CAMHS services.		• Primary Care/VCSE • Communities	March 2023	help, Universal and Early Help services Evidence of signposting to support whilst waiting for CYP SEMH needs assessment and treatment		🟨
4.3 Reduce waiting times for Speech Language Therapy assessment and treatment and strengthen support offer whilst waiting.						
4.3.1 Review the service offer across all key stakeholders to increase the understanding of current service pathways for CYP who require support with their Speech Language and Communication needs.	Service Manager Speech Communication & Language services BDCFT	• CYP/Parents/Carers • Education • Communities • Provider services • 0-19 services • Prevention/Early Help • Primary Care • Public Health	March 2023	Current service pathway is mapped and all key stakeholders are aware of current service offer		
4.3.2 Review, define and communicate the referral criteria for Specialist Speech and Language Therapy to all key stakeholders to ensure that only CYP who need specialist Speech and Language Therapy are referred for assessment and treatment.	Service Manager Speech Communication & Language services BDCFT	• CYP/Parents/Carers • Education/Ed Psych • Communities • Provider services • 0-19 services • Prevention/Early Help • Primary Care • Public Health Prevention/Early Help	March 2023	Referral criteria is reviewed and signed off and is shared with key stakeholders including children, young people and families		

4.3.3 Using a co-production approach improve service provision across the self-help, universal and early intervention offer for Speech Language and Communication needs to ensure support is available whilst CYP wait for assessment and to ensure that children/young people and families receive advice and support as early as possible to reduce the need for referral to specialist Speech and Language services.	Service Manager Speech Communication & Language services	• CYP/Parents/Carers • Education • Communities • Provider services • 0-19 services • Prevention/Early Help • Specialist Nursing • Primary Care • Public Health	March 2023 September 2023 March 2023	Self-help, Universal and Early Help pathway is agreed Evidence of the delivery of support for CYP with speech communication and language needs from self-help, universal offer and early help and services Evidence of signposting to support whilst waiting for Speech Communication and Language needs assessment		
4.4 Improve timeliness of provision of specialist equipment and wheelchairs for CYP with SEND.						
4.4.1 Review pathways, including commissioning and funding arrangements, across all key stakeholders to increase understanding of current service pathways in relation to the provision of wheelchairs and specialist equipment.	Senior Manager Integration and Change BDC HCP	• CYP/Parent Carers • BACES • NHSE • Provider Services • Local Authority • Education • SEN Team	December 2022	Current service pathway is mapped and all key stakeholders are aware of current service offer		
4.4.2 Using co-production develop improved pathways to	Senior Manager	• BACES • NHSE	June 2023	Evidence of the commissioning,		

increase efficiency and ensure timely provision of specialist equipment and wheelchairs.	BDC HCP	• Provider Services • Local Authority • Education	 March 2023	funding, delivery and clinical support pathway for CYP aged 0-25 who require a wheelchair or specialist equipment Evidence of information guide re how to access support whilst waiting for a wheelchair or specialist equipment		
4.4.3 Review capacity of OT and Physiotherapy services to ensure timely assessment and review of CYP who require specialist equipment and wheelchairs.	Service Manager OT and Physiotherapy BTHFT	• Provider Services • Council	March 2023	Analysis of OT and Physio workforce across all key stakeholders who deliver assessments for wheelchairs and Specialist Equipment for CYP aged 0-25 who have SEND		
4.5 Ensure dynamic support co-ordination approach is embedded for CYP with a Learning Disability (LD), Autism, Mental Health (MH) and/or SEMH need.						
4.5.1 Work with key stakeholders to launch and embed the dynamic support co-ordination approach to ensure that the HCP effectively support children and young people who have LD, Autism, MH or SEMH who are at risk of admission to specialist hospital or who are at	Senior Head of Integration & Care CYP LD/ND BDC HCP	• Provider services • Education • Local Authority • VCSE • Communities, CYP, Families • Social Care	March 2023	Evidence that Dynamic support co-ordination approach is launched and meets statutory functions		

risk of multiple and irretrievable breakdown of their care/placement.		• NHSE • Primary Care • NHSE				
4.5.2 Ensure effective reporting and governance is in place across the HCP to influence strategic planning, commissioning and partnership working to support effective service provision for CYP with Autism, LD, MH, SEMH who have the most complex and intensive support needs.	Senior Head of Integration & Care CYP LD/ND BDC HCP	• Provider services • Education • Local Authority • VCSE • Communities, CYP, Families • Social Care • NHSE	September 2023	Evidence of effective reporting and governance re CYP DSC (number of referrals and discharges per month, reason for inclusion on CYP DSC, meetings where reported etc)		
4.6 Increase the uptake of Annual Health Reviews for CYP aged 14-25 who have a Learning Disability.						
4.6.1 Review the Annual Health Review pathway across all key stakeholders to understand the current process and pathway for CYP who are eligible for an Annual Review.	Senior Head of Integration & Care CYP LD/ND BDC HCP	• Primary Care • Education • Social Care • Provider services • Specialist School Nursing	March 2023	Current service pathway is mapped and all key stakeholders are aware of current service pathway		🟨
4.6.2 Using co-production develop improved pathways across all key stakeholders to increase efficiency, raise awareness and increase uptake of Annual Health Reviews for CYP aged 14-25 who are eligible for an Annual Review.	Senior Head of Integration & Care CYP LD/ND BDC HCP	• Primary Care • Education • Social Care • Provider services • VCSE • CYP/Families	March 2023 January 2023	Evidence of pathway re how CYP aged 14-25 who are on the GP LD register access the Annual Health Check Pathway communicated to all key stakeholders		🟨

4.7 Improve the timeliness of Initial Health Assessments (IHA) and Review Health Assessments (RHA) for children in care.						
4.7.1 Review the IHA & RHA pathway across all key stakeholders to understand the current process and pathway for CYP who are eligible for review.	Senior Head of Integration & Care – women's, children's & maternity BDC HCP	• Primary Care • Education • Social Care • Provider services • Specialist School Nursing services	March 2023	Current service pathway is mapped and all key stakeholders are aware of current service pathway		🟨
4.7.2 Work with social care to ensure consent is provided for CYP who require an Initial Health Assessment.	Assistant General Manager 0-19 & Specialist Services	• Provider services • Local Authority • Health & Care Partnership • Designated Doctor	April 2023	Consent is provided for 100% of CYP who require a Health Assessment		
4.7.3 Using co-production develop improved pathways to increase efficiency and improve partnership working to ensure IHAs and RHAs are completed within recommended timescales.	Senior Head of Integration & Care – women's, children's & maternity BDC HCP	• Provider Services • BD&C HCP • CYP, families • Primary Care • Social Care • Specialist School Nursing services	March 2023	Evidence of pathway re delivery of Initial and Review Health Assessments within statutory timescales for children and young people who are in care		

How will we know that what we are doing is making a Difference?

Outcome Indicators WSOA 4		Current baseline	Mar 23	Sept 23	Mar 24	Sept 24
1.Autism/ADHD	Average length of wait in weeks between referral and first appointment at the end of the reporting month (total)	31 weeks (June 2022)	31 weeks	29 weeks	27 weeks	26 weeks
	Longest wait in weeks between referral and first appointment at the end of the reporting month (total)	101 weeks (June 2022)	90 weeks	60 weeks	52 weeks	45 weeks
	% of referrals for diagnostic assessment started within 13 weeks of referral	0%	0.5%	3%	6%	12%
	Caveat: To deliver the above a modelling of the additional resource needed to achieve NICE guidance will be undertaken and the required resource identified.					
	By March 2023 Signposting Information will be available for CYP/Parent Carers about the support that is available while CYP are waiting for ADHD/Autism assessment		Signposting Information available			
2. CAMHS	By September 2023 90% of CYP will wait no longer than 18 weeks between referral and commencement of treatment in CAMHS *Excludes Eating Disorders and Neurodiversity referrals	85%	85%	90%	90%	90%
	By March 2023 Signposting Information will be available for CYP/Parent Carers about the support that is available while CYP are waiting for commencement of CAMHS assessment and treatment		Signposting Information Available			
3. Speech Language Therapy	By June 2024 90% of CYP will begin assessment by Speech Language Therapy services 18/52 following referral for assessment	54%	65%	75%	85%	90%

	By March 2023 Signposting Information will be available for CYP/Parent Carers about the support that is available while CYP are waiting for Speech Language Therapy assessment and treatment		Signposting Information Available			
4. Specialist Equipment	By September 2024 80% of CYP receive specialist equipment within 18/52 following referral for assessment		50%	65%	75%	80%
	By March 2023 Information and guidance will be available for CYP/Parent Carers about the support that is available while CYP are waiting for Specialist Equipment		Guidance Available			
5. Wheelchairs	By June 2023 80% of CYP receive a wheel chair within 18/52 following referral for assessment	75%	80%	80%	80%	80%
	By March 2023 Information and guidance will be available for CYP/Parent Carers about the support that is available while CYP are waiting for a Wheel Chair	🟩	Guidance Available			
6. Dynamic Support	Evidence of functioning CYPDSC (number of referrals and discharges per month, number of CYP on DSC, minutes of Panel)	🟩	Evidence Available			
7. Annual Health Checks for CYP (14-25) with LD	For the Year 2022/23 70% of CYP aged 14-18 who are on the GP LD Register will receive an Annual Health Check For the Year 2023/24 80% of CYP aged 14-18 who are on the GP LD Register will receive an Annual Health Check	2021/22 66%	70.0%	YTD 20.0%	YTD 80.0%	YTD 20.0%
	For the Year 2022/23 70% of CYP aged 19-25 who are on the GP LD Register will receive an Annual Health Check For the Year 2023/24 80% of CYP aged 19-25 who are on the GP LD Register will receive an Annual Health Check	2021/22 67%	70.0%	20.0%	80.0%	20.0%
8. IHA/RHA for CLA	By Sept 24 90% of CYP will receive an Initial Health Assessment within 20 working days after coming into care	4%	40%	60%	80%	90%
	By Sept 24 90% of CYP will receive a Review Health Assessment within statutory timescales (6/12 for 0-5 and 1 year for CYP 5-18)	37%	55%	75%	85%	90%

Improvement Area 4 Impact Statement

The table below sets out what children, families and partners can expect, as a result of the actions set out in this WSOA.

Objective	How will this make a difference to children and families?	An example in practice
4.1 To reduce waiting times for autism/ADHD assessment and strengthen the support offer whilst waiting for assessment,	Ensuring timely assessment for suspected autism/ADHD will help children and young people understand themselves better and will also help their parent carers, families and other key people such as school and health care staff understand them better too. Improved understanding means that if additional support is needed this can be provided in the right way to help the child/young person achieve the best outcomes they can in education and in life. Making sure support and information is available whilst waiting for assessment also helps children and young people, their parent carers and families access the best support they can as soon as they can. This helps prevent any challenges or difficulties increasing and becoming worse.	Alice was referred for assessment for ASD/ADHD. Alice her Mum and Dad were provided with information and guidance about support that is available whilst Alice was waiting for assessment. Using the information provided Alice's Mum and Dad accessed an understanding Autism workshop provided by BEAT and are receiving peer support and attending social events with Alice via AWARE membership. They now have a much better understanding of Alice's needs and feel more confident in anticipating and managing Alice's social interactions and behaviour. This had led to them now spending more quality time as a family.
4.2 To reduce waiting times for CAMHS services and strengthen support offer whilst waiting for assessment and treatment	Ensuring timely assessment for children and young people's mental health needs is important so that children and young people, their parent carers, families and other key people are aware of the emotional and mental health needs and difficulties that a child and young person may be experiencing This improved understanding means that if additional specialist mental health support is needed this can be provided to help the child/young person overcome, or better manage, their mental health difficulties and help	**J**igna is referred to CAMHS by her GP as she has been experiencing long-standing mental health challenges, including high levels of anxiety and escalating self-harming behaviours. When CAMHS receive the referral, the Duty Team contact Jigna and her family to talk about how things are and what things they can support her with. Following this initial assessment, Jigna is sent a welcome booklet, which has been designed by a young person who has previously received support from CAMHS services. The welcome

	them achieve the best outcomes they can in education and in life. Making sure support and information is available whilst waiting for assessment and treatment helps children and young people, their parent carers and families know about the support that is available while they wait; this enables them to access support and advice as soon as they can. This helps prevent any challenges or difficulties increasing and becoming worse.	booklet provides details about CAMHS; what to expect and the different services and types of support that CAMHS offers. This helps Jigna feel less anxious about seeing her CAMHS worker. Initially Jigna is worried about working with CAMHS, however over time Jigna begins to learn strategies to better manage her feelings and her anxiety and self-harming improves.
4.3 To reduce waiting times for SaLT assessment and strengthen support offer whilst waiting for assessment and treatment	Ensuring timely assessment for children and young people's speech and language therapy is important so that children and young people, their parent carers, families and other key people such as schools are aware of the speech language and communication needs and difficulties that a child and young person may be experiencing This improved understanding means that if additional specialist speech and language therapy is needed this can be provided to help the child/young person improve their speech, language and communication and help them achieve the best outcomes they can in education and in life. Making sure support and information is available whilst waiting for assessment and treatment helps children and young people, their parent carers and families know about the support that is available while they wait; this enables them to access support and advice as soon as they can. This helps prevent any challenges or difficulties increasing and becoming worse.	Zayn is 4 years old and has significant delay in his speech and language. He was referred to Speech and Language Therapy following his 2-year review by his Health Visiting team Speech Therapists have been working with Zayn, his family and his nursery setting; providing advice and guidance to help him develop his speech and supporting him use Makaton and picture cards so he can express himself and make his needs known. He is making good progress and is more settled and engaged in nursery. The Speech Therapist has been working with Zayn's new school ahead of him starting in September so that school are aware of Zayn's needs and so they know how best to support this speech, language and communication needs. This will help Zayn settle into his new school and support his learning and social interactions with his friends and teachers.

4.4 To improve timeliness of provision of specialist equipment and wheelchairs for CYP with SEND	Children and Young People will receive the postural and mobility equipment that is needed in a timely way to maintain or optimise their physical functioning and enable participation in age-appropriate activities including family life, social events and education. Parent carers will have improved quality of life as appropriate supportive equipment in place. An efficient pathway for equipment provision releases therapist time to support families in use of equipment and the associated health and well-being gains.	Darryl's walking ability has declined and he is referred to wheelchair services for assessment. Darryl and his family receive a welcome pack explaining the wheelchair service, the care pathways and processes and the expected time to assessment and delivery of a wheelchair. After Darryl receives his wheelchair he can move about school more easily and get to his classes on time; he can also go outdoors at break time with his classmates. His family are able to join in more social activities and doing daily activities such as going to the shop for groceries is much easier. This impacts positively on Darryl and his families, mental and physical health and well-being.
4.5 To ensure a dynamic support co-ordination (register) approach is embedded for Children Young People with Autism, a Learning Disability, Mental Health or Social Emotional Mental Health need	Dynamic Support Coordination (DSC) aims to ensure that children and young people with Autism, a Learning Disability, Mental Health or Social Emotional Mental Health need receive the right care, education, and treatment in their local community whenever possible, by working with the child/young person, their parent carers and the agencies who are involved in their care. Dynamic Support Coordination is about supporting services to come together to discuss whether changes can be made to care, education and/or treatment in a pro-active and timely manner, to prevent escalation to a crisis situation. The ambition is to prevent admission to a specialist in-patient hospital, breakdown of care or contact with the criminal justice service, ensuring children/ young people remain at home, or as close to home as possible, wherever possible	Frank is 16 and lives at home with his Dad and 2 brothers; he has a Learning Disability. Dad is very experienced in supporting Frank and understands his needs. He is well supported by extended family and friends. Recently Frank's behaviour has become increasingly erratic and agitated and he has started becoming aggressive towards Dad and his brothers. Dad is struggling to understand the reasons for the change in Frank's behaviour and is concerned Frank may hurt him or his brothers; he is worried that Frank may not be able to remain at home. Dad gives consent for Frank to join the Dynamic Support Co-Ordination. Services from across Specialist services discuss the best way to support Frank and his family; Learning Disability Trauma Informed Care (LDTIC) services offer to work with Dad and Frank to try and understand the changes in Frank's behaviour. The LDTIC team identify that changes at Frank's school have led to

	Dynamic Support Coordination is about ensuring local services know the people who are likely to need additional support and aims to enable services to deliver the right support at the right time.	the change in Frank’s behaviour. Strategies are put in place with both school and home and Frank’s behaviour settles and becomes less agitated. Frank is able to remain at home with his family
4.6 To increase the uptake of Annual Health Reviews for CYP aged 14-25	Annual Health Checks for Children and Young People aged 14-25 years who had a Learning Disability are important to help the young person to stay well. Having an Annual Health Check with the GP practice also helps the young person build relationships with staff at the practice and ensures that they start to know the people and the environment. If they are then unwell & need to visit the GP, the experience is less traumatic. It also helps people get the medications they need. Annual visits, also helps the GP practice identify family carers and ensure they are offered health checks and relevant vaccinations so that they themselves remain well and healthy	Magda is 20 years old has a learning disability; she becomes scared and upset when she must visit places that she is unfamiliar with. She has been visiting her GP practice for the past 5 years and is now familiar with the staff and the practice environment. At her Annual Health Check, the practice nurse finds that Magda has an infection in her urine. Magda is prescribed some liquid antibiotics as the practice nurse knows this is easier for Magda to manage. The urine infection clears up and Magda has less pain and discomfort when she goes to the toilet; she is happier and her well-being improves.
4.7 To improve the timeliness of Initial Health Assessments and Review Health Assessments for children in care	Often Children in Care have experienced significant adverse childhood trauma; evidence indicates that children experiencing adverse trauma have increased health and well-being needs and poorer health outcomes. Ensuring timely Initial and Review Health Assessments is therefore important to ensure that the health needs of children/young people in care are identified as soon as possible; this is so services can be offered to meet needs and enable children in care to achieve the best health and life outcomes.	Lyla was placed in care when she was 13 years old. She had previously lived with her mum and stepdad who both regularly drank alcohol excessively and used drugs. Lyla’s initial health assessment identified that she was extremely underweight, and she had low iron levels. This left her feeling exhausted and unable to concentrate in class. She was referred to a dietician and placed on iron replacement supplements. She has since increased her weight to a healthy BMI and her iron levels have improved. She is now able to concentrate in class and she has more energy. Teachers report that she is progressing well academically and she is enjoying playing games and sports with her friends.

IMPROVEMENT AREA 5

Education, health and care services do not work together well. The arrangements for joint commissioning are underdeveloped.

SRO: Jane Wood, Assistant Director, Commissioning and Integration

We recognise that our joint commissioning for children and young people with SEND has been under-developed and there is a need to increase the pace of change, alongside stronger collaboration across education, health and care, and children and families. We are committed to collectively reform our partnerships and governance across the key partners to co-produce our joint commissioning plans.

We will use the principles for working together outlined in the Bradford District and Craven Health and Care Partnership Strategic Partnering Agreement (SPA) to build relationships with a collective focus to support clearer working arrangements. The development of joint commissioning for SEND is a recognised priority area of development. We will optimise the use of all our shared resources to support our children and young people with SEND to achieve their maximum potential.

We will ensure that our commissioning strategy and intentions are informed by clear assessment of need, and we will use a range of intelligence, from JSNA to EHCPs. We will work with partners, to develop a strong and shared understanding of our population need to ensure that our services can meet the needs of children and young people with special education needs and disabilities.

We will respond to the need for education, health and care services to demonstrate that we can work together. We will develop our arrangements in line with the requirement of the SEND Code of Practice. We are fully committed to the principles of co-production in designing our new services. This will allow us to integrate the voices and aspirations of children, young people and their families into the design, delivery and evaluation of our joint commissioning model and services.

The SEND inspection has refreshed our commitment to creative partnership working with our communities to reduce inequalities and to jointly plan, deliver and evaluate our services that are collaboratively commissioned.

We will align our approach to joint commissioning for SEND with the emerging joint commissioning and decommissioning arrangements for the Bradford District and Craven Health and Care Partnership; to ensure consistency of approach in terms of shared priorities, alignment of systems and process for decision making and dispute resolution. This approach will also allow us to ensure that any calls on the Partnership's resources are managed in a co-ordinated manner and consider the wider impact on stakeholders and partners.

We will improve relationships across health and care by recognising and owning the challenge. Recent changes in leadership and staffing are already beginning to cement effective and productive discussions. We are holding partner 'checkpoint meetings' and 'listening events' to ensure our joint commissioning brings together education, health, social care and parent/carers along with the 'lived experience' of children and young people with SEND.

We are committed to developing commissioning strategies and plans to increase the availability of services identified in the inspection. This will incorporate new plans to reduce waits and increase capacity in services including, but not exclusively related to: CAMHS, ADHD/ASD Services, Speech and Language Therapy, Deaf Signing clubs, Wheelchair Services, Specialist Equipment and Short Breaks provisions.

We will ensure that the supporting legal and longer-term financial infrastructure is robust to support our ambitions. We will do this by contributing to the refresh of our Section 75 (S75) Agreement which is being managed by the Health and Care Partnership's Planning and Commissioning Forum.

As a matter of priority, we are working on commissioning plans to address the specific gaps and area of weakness raised by the inspection. Our joint commissioning strategy responds to all levels of provision to meet need from information and advice to specialist placement sufficiency.

Table 5: Improvement Area 5 – Education, health and care services do not work together well. The arrangements for joint commissioning are underdeveloped.

Activity	Lead	Partners	Timeframe	Success/Measure	Progress	RAG
Objective 5.1 To work together in-line with Bradford District and Craven's Strategic Partnership Agreement to deliver arrangements for agreeing the education, health and social care provision required by local children and young people with SEN or disabilities. Objective 5.2 To effectively work as a partnership, to co-produce and jointly commission services and provision which meet the needs of children and young people (0-25). Objective 5.3 To expand our use of joint commissioning infrastructure to improve provision and outcomes for children and young people (0-25).						
Objective 5.1 Work together in-line with Bradford District and Craven's Strategic Partnership Agreement to deliver arrangements for agreeing the education, health and social care provision required by local children and young people with SEN or disabilities.						
5.1.1 To use the principles for working together outlined in the Bradford District and Craven Health and Care Partnership Strategic Partnering Agreement to build relationships with a collective focus and to support clearer working arrangements.	Assistant Director CBMDC Associate Director BDC HCP	• Children and young people • Parents/carers • BDC HCP • Public Health • Social Care • Education • Health providers who hold resources within the HCP	December 2022	SPA Principles for working together shared widely		🟨
5.1.2 To strengthen SEND joint commissioning governance structures to ensure strong accountability, effective	Assistant Director CBMDC	• Children and young people • Parents/carers • BDC HCP	March 2023	Terms of Reference, including governance structure, reviewed, updated.		🟨

progress tracking and timely problem solving.	Associate Director BDC HCP	• Public Health • Social Care • Education • NHS Providers		Revised arrangements agreed by SSPB and System Planning and Commissioning Forum		🟨
Objective 5.2 To effectively work as a partnership, to co-produce & jointly commission services and provision which meet the needs of children and young people (0-25).						
5.2.1 To support the development of a System Joint Commissioning Strategy which will align with the SEND specific Joint Commissioning Strategy 2020/23. The System Joint Commissioning Strategy will outline our principles for joint commissioning and our approach to decommissioning.	Assistant Director CBMDC Associate Director BDC HCP	• Children and young people • Parents/carers • BDC HCP • Public Health • Social Care • Education • NHS Providers	June 2023	Partnership Commissioning Strategy Published on Local Offer and Local Partnership Websites		
5.2.2 To publish an updated JSNA for SEND Services to show the current needs for CYP with SEND across the Bradford District.	Director of Public Health CBMDC	• Parents and Families Groups • Peoples Commissioning • Education and Learning Directorate • Public Health • NHS Foundation Trusts	April 2023	JSNA Published on Local Offer and Local Partnership Websites		

5.2.3 To develop mechanisms to ensure that our commissioning strategy and intentions are informed by clear assessment of need. This will include: • The voice of CYP • The voice of parents/carers • Service gaps identified through the EHCP process	Assistant Director CBMDC Associate Director BDC HCP	• Children and young people • Parents/carers • BDC HCP • Public Health • Social Care • Education • NHS Providers	March 2023	Partnership Commissioning Strategy and Commissioning Intentions published on Local Offer and Local Partnership Websites		▨
5.2.4 To identify budgets aligned to SEND service provision to develop transparency and assurance in terms of spend across all areas.	Assistant Director CBMDC Associate Director BDC HCP	• BDC HCP • Public Health • Social Care • Education • NHS Providers	December 2023	Baseline understanding of SEND investment across BDC HCP		🟧
5.2.5 To contribute to the refresh of the system S75 Agreement.	Assistant Director CBMDC Associate Director BDC HCP	• BDC HCP • Public Health • Social Care • Education • NHS Providers	April 2023	Relevant SEND commissioning arrangements reflected in the S75 agreement		🟧
5.2.6 To have oversight of all SEND specific jointly commissioned service provision and aligned services to inform future commissioning decisions.	Assistant Director CBMDC Associate Director BDC HCP	• Children and young people • Parents/carers • BDC HCP • Public Health • Social Care	December 2023	To have sight of all relevant data and annual reports		▨

		• Education • NHS Providers				
Objective 5.3 To expand our use of joint commissioning infrastructure to improve provision and outcomes for children and young people (0-25)						
5.3.1 New Service Commission Plans for areas highlighted in the SEND Inspection. Ensure alignment with proposed overarching joint commissioning strategy to ensure we identify and address any gaps in service delivery.	Assistant Director People's Commissioning	• BDC HCP • Public Health • Social Care • Education • NHS Health Providers	March 2023	Joint commissioning plan to reduce waiting times for CAMHS services and strengthen support offer whilst waiting for assessment		
				Joint commissioning plan to reduce waiting times for autism/ADHD assessment and strengthen the support offer whilst waiting for assessment.		
				Joint commissioning plan to reduce waiting times for SaLT assessment and strengthen support offer whilst waiting for assessment.		
				Joint commissioning plan to improve timeliness of provision of specialist equipment and wheelchairs for CYP with SEND.		

				Joint commissioning plan to support delivery of dynamic support co-ordination approach		
				Joint Commissioning Plan to increase availability of Short Breaks for children with Disabilities.		
				Joint Commissioning Plan to review children in residential and out of district placements.		
				Joint Commissioning Plan to develop clubs for signing activities		

How will we know that what we are doing is making a difference?

Outcome Indicators

- Demonstrate the principles of the Bradford District and Craven Health and Care Partnership Strategic Partnering Agreement (SPA)
- Revised Terms of Reference and Governance in place
- Contributed to the development of the Partnership Commissioning Strategy which will reflect an understanding of the needs of children and young people with SEND and aligns with the system vision of ‘supporting children to maximise their learning, growth and development and remain happy, healthy at home wherever possible’
- An established process for ensuring our commissioning strategy is informed by clear needs assessment including, but not exclusively, the voice of the children and young people, parents and carers and the JSNA
- An understanding of the budgets aligned to SEND service provision
- Contributed to the refresh of the System Section 75 agreement
- Access to all relevant data and annual reports to inform our commissioning decisions
- A process in place to ensure the full spectrum of joint commissioning approaches are considered for all SEND transformation areas

Impact Measures

All relevant colleagues aware of the Bradford systems commitment to joint commissioning and their individual responsibilities towards the development and delivery of the strategy;

Partners across the local system hold each other to account for delivery of outcomes, with regular monitoring and constructive challenge processes in place; and

Services and provision match need in local area according to local intelligence including the JSNA and are published on the Local Offer.

Improvement Area 5 Impact Statement

The table below sets out what children, families and partners can expect, as a result of the actions set out in this WSOA.

WSOA 5 Objectives	How will this make a difference to children and families?	An example in practice
5.1 To work together in-line with Bradford District and Craven's Strategic Partnership Agreement to deliver arrangements for agreeing the education, health and social care provision required by local children and young people with SEN or disabilities.	New arrangements consider the whole need of children and families, putting children's commissions at the centre of our approaches to understand the needs of the population. Senior leaders can consider wholly the types of arrangements and services are needed for the future in line with the new SEND & Inclusion Strategy.	The Children's Health and Care Partnership Board consider a range of emerging trends relating to service commissions for children. Using the SPA Agreement and Commissioning Strategy they endorse medium term business cases to ensure that the needs of children are met. This provides commissioners with first stage approval to go to the internal and external markets to provide services which are then enabled over an 18 month period forecasting the changing trends of need amongst the SEND population of children.
5.2 To effectively work as a partnership, to co-produce and jointly commission services and provision which meet the needs of children and young people (0-25).	Families who have specific needs have those met ahead of them realising that these services are needed. Health, Education and Care intelligence accurately predicts that greater support is needed in differing parts of the system and longitudinal planning is put in place providing the right support at the right time.	Service needs are articulated within the JSNA show a rising trend in the numbers of children who require further support and enrichment within schools for signing. A business case is brought to the Health and Care Partnership Board showing that greater support is required in 5 specific schools in the District. A new alliance partnership commission is put in place where one school will act as lead provider to other schools to support signing in schools across Bradford. This commission has KPI's that are SMART built in and progress is tracked for improving outcomes alongside other core values such as rising and decreasing needs / usage of services.

5.3 To expand our use of joint commissioning infrastructure to improve provision and outcomes for children and young people (0-25).	Greater availability of services with reduced waiting times is provided in Bradford due to a mixture of aligned budgets, pooled budgets and agreements on commissioning and decommissioning needs for the District. These are clearly stated and signposting for services is shown on the Local Offer alongside the pathways to access these services.	A review of Speech and Language Therapy is completed and an opportunity to align initially and pool the budgets the following year is agreed. Health agrees to be the lead commissioner to the Districts NHS Foundation Trusts, with Local Authority guidance on requirements to go into a revised contractual arrangement. A suite of indicators is agreed and regular reporting is provided via Providers to show the usage and needs of the service to inform contract monitoring and future commissioning activities.

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Choice in mental health care

Guidance on implementing patients' legal rights to choose the provider and team for their mental health care

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Contents

Foreword

We are radically transforming mental health care in England.

The government has published its plans to provide better access to mental health services1 over the next five years and the NHS Five Year Forward View2 emphasises the need for the NHS to drive towards an equal response to mental and physical health, and towards the two being treated together. The Five Year Forward View commits to increasing the direct control patients have over the care that is provided to them and making good on the NHS' promise to give patients choice over where and how they receive care.

In physical health, we know that only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. In introducing choice in mental health, we have the opportunity to accelerate the drive for greater patient involvement in their care.

The changes in law that have given patients with mental health conditions the same legal rights as they have had in physical health services are significant steps towards parity. They are part of the more significant shift to increase the direct control patients have over their care and every one of us working in mental health has a part to play to help implement these rights and make them work well for patients.

Transparency is at the heart of making choice work well for patients. This includes transparency about the services available, the outcomes they offer patients, the experience that patients have when using them and the ways in which care can be delivered: at home, in communities through technology, as well as in traditional care settings. By gathering and sharing information about services we help patients make well-informed, meaningful choices, we empower healthcare professionals to compare themselves with others as a spur to improved performance, and we help CCGs and NHS England commission the right services, of the right quality, to meet patients' needs and preferences.

This guidance has been developed with colleagues from across the mental health sector. It seeks to promote a common understanding of what mental health patients' legal rights are, where they apply, and what they mean in everyday practice. It should enable consistency in the application of these rights, while also acknowledging the need for clinical judgments and decisions according to the circumstances of individual patients.

Embedding the legal rights to choice in mental health will take time and effort to achieve, and this guidance is part of a wider programme of work to support the implementation of choice.

I look forward to continuing to work with you.

Bruce Keogh.

Professor Sir Bruce Keogh
National Medical Director NHS England

The Choice Offer

Patients' legal rights to choice

Patients' legal rights to choice in mental health were introduced in 2014 as part of the drive to achieve parity with physical health and increase patients' direct control over their care. We know from physical health that these legal rights require interpretation to ensure that they are well understood and work well for patients. This guidance seeks to provide a clear interpretation of the legal rights that is meaningful to the mental health sector, and to support their consistent application.

The legal rights to choice covered in this guidance are:

- patient choice of mental healthcare provider
- patient choice of mental healthcare team

The regulations introducing these legal rights state that: *Patients must be offered, in respect of a first outpatient appointment with a team led by a named consultant or a named healthcare professional, a choice of any clinically appropriate health service provider with whom any relevant body has a commissioning contract for the service required as a result of the referral, and a choice of a team led by a named consultant or a named healthcare professional. This is subject to exclusions set out in legislation3.*

This guidance seeks to interpret these regulations and set out the principles for how these legal rights to choice should operate. It is important to note that the right to choice does not mean that a patient only has their first outpatient appointment with their chosen provider: consistent with physical health care, once a patient has chosen a provider, that provider will normally treat the patient for their entire episode of care, unless the patient's diagnosis changes significantly.

What do these rights mean?

The legal rights to choice of mental health provider and team apply when:

- the patient has an elective referral for a first outpatient appointment
- the patient is referred by a GP
- the referral is clinically appropriate
- the service and team are led by a consultant or a mental healthcare professional
- the provider has a commissioning contract with any Clinical Commissioning Group (CCG) or NHS England for the required service

No prior commissioner approval is required for consultant-led elective care or in the case of mental health, services led by a healthcare professional, where the patient has exercised choice of provider under the legal rights set out in the NHS Constitution.

Commissioners may put in place arrangements such as single points of access (SPA). However, an SPA should not have the effect of restricting patient choice and where patients have a legal right to choose their provider, this should always be enabled.

Key terms explained:

- **Elective referral**
  - A referral by a GP where a patient wishes to be referred for treatment that is not urgent or emergency (crisis) care.
- **Outpatient appointment**
  - An outpatient appointment is any arrangement for a patient to receive elective care from a healthcare professional, where the patient is not admitted as an inpatient.
- **First outpatient appointment**
  - A patient's first appointment with their chosen provider at the start of their new episode of care following a referral by a GP.
- **Clinically appropriate**
  - This is a clinical judgement about what is in the best clinical interests of the patient, working within the published National Institute for Health and Care Excellence (NICE) guidelines and specifications. See fuller description of clinical appropriateness on page 17.

Yellow highlighting = updated from the Guidance published in Feb 2018

What do these rights mean?

- **Team, led by a consultant or a mental healthcare professional**
  - In physical health, elective referrals to outpatient services are often to teams led by a consultant in hospital outpatient settings. In contrast, in mental health, much of the equivalent provision occurs in the community and is delivered by a variety of mental health professionals. To make the legal rights to choice work well and on an equivalent basis in mental health, the rights apply to teams led by a mental health consultant or other mental healthcare professional.

  - For ease of reference, throughout this guidance we use the term 'team led by a healthcare professional' to cover both.

Further information:

The Government's mandate to NHS England states that from April 2015 people with long term conditions who could benefit will have the option of a personal health budget. Services provided by a personal health budget are agreed during the care planning process, and operate outside of the independent funding review panel route. Further information is available online5.

How far do these choices extend?

Patients' legal rights to choice in mental health are part of the drive to achieve parity with physical health. In seeking to deliver this, the following should be considered:

Community care
Much mental health outpatient provision occurs in the community, and such provision is covered by the legal rights. Where the patient lives outside the area where the chosen mental healthcare community service is delivered, it will be necessary for the patient and the GP to consider how the patient would be able to travel to and from the provider, when making a choice of provider. It is important to note that there is no obligation on the provider of community services to travel to the patient. This is to facilitate as wide a choice as possible for patients while not placing impractical demands on providers.

Primary care
Mental health services provided under a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) primary care contract are not covered by the legal rights to choice of provider and team.

Section 75 Agreements with local authorities
The legal rights to choice apply when the chosen service is commissioned under a Section 75 Agreement of the Health Act 2006 with a local authority.

Self-referrals
As in physical health, patients' legal rights to choice apply following a referral by a GP to any provider that has a Commissioning Contract with any CCG or NHS England for the required service. Patients may access some services, such as Improving Access to Psychological Therapies (IAPT) and Children and Adolescents Mental Health Services (CAMHS), via self-referral or other locally agreed referral processes, e.g. through schools. In these instances, patients' choices will be determined by commissioners' local choice offers.

Beyond the first outpatient appointment
Having chosen a provider, the patient must be treated by that provider for the entire episode of care for which the patient was referred (unless the provider does not provide the clinically appropriate service that the patient needs or, in the provider's reasonable professional opinion, a patient is unsuitable to receive the relevant service, for as long as they remain unsuitable).

If a patient's diagnosis changes significantly, the provider should contact the patient's GP to discuss whether it is still clinically appropriate for the patient to be treated by that provider and whether the commissioner will continue to fund the episode of care.

When do the rights to choice not apply?

There are some exclusions from these legal rights to choice.

These are where a patient is:

- already receiving mental health care following an elective referral for the same condition
- referred to a service that is commissioned by a local authority, for example a drug and alcohol service (unless commissioned under a Section 75 Agreement)
- accessing urgent or emergency (crisis) care
- accessing services delivered through a primary care contract
- in high secure psychiatric services
- detained under the Mental Health Act 1983
- detained in a secure setting. This includes people in or on temporary release from prisons, courts, secure children's homes, certain secure training centres, immigration removal centres or young offender institutions
- serving as a member of the armed forces (family members in England have the same rights as other residents of England).

Key terms explained:

- **Already receiving mental health care following an elective referral for the same condition**
  - The patient is already being treated by a healthcare professional, following an elective referral, for the condition for which they are presenting to their GP.
- **Urgent or emergency (that is, crisis) care**
  - In the same way that the legal rights to choice of provider do not apply in the case of a physical health care emergency, such as a heart attack or stroke, they similarly do not apply in situations requiring mental health crisis care. The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis6 sets out an effective approach to ensuring people experiencing mental health crisis can access the support they need, when they need it.
- **Services delivered through a primary care contract**
  - Mental health services provided under a GMS, PMS or APMS primary care contract are not covered by the legal rights to choice of provider and team.

Meaningful choice

The legal rights to choice must be offered at points where patients can make meaningful decisions about the provider and team from which to receive their care7. This decision might, for example, take place in their GP's surgery, or when a patient is assessed following a GP referral. Further detail is provided below and in in the flow diagram on page 11.

Patient choice and the Mental Capacity Act 2005

As a guiding principle, patients should be involved as much as possible in decisions about their care, as set out in the Government's response to Liberating the NHS: No decision about me, without me8.

Across the range of mental health conditions that patients might experience, patients may be vulnerable and their ability to exercise choice that is clinically appropriate could be compromised. Referrers are required under the Mental Capacity Act 20059 to support their patients in making decisions about their care. The Act requires all health professionals to take 'all practicable steps' to help people make their own decisions. When an impairment is such that the patient lacks capacity, the Act requires that he or she must be involved as much as possible in any decisions about their best interests. Moreover, when capacity is likely to deteriorate over time, the principles of the Act should form the basis of any discussions about the future.

GPs offering choice

In many cases the patient will have a long term relationship with their GP. Their GP will be well placed to understand the needs of the patient and have a meaningful conversation with the patient about what is clinically appropriate given the patient's needs and preferences.

GPs should have as full a choice conversation with their patients as possible. This may include the need for further clinical assessment to determine the diagnosis and potential care options, or consideration of how the patient would be able to travel to and from a provider (such as a distant community healthcare provider which does not have an obligation to travel to the patient).

Assessment following GP referral

Prior to receiving care, a patient might need to be assessed. There are different models in use across the country, some of which offer a predominately administrative referral service while others offer a clinical assessment where the patient is reviewed by a healthcare professional and triaged to the most appropriate service.

Meaningful choice

Common terms in use for such services include:

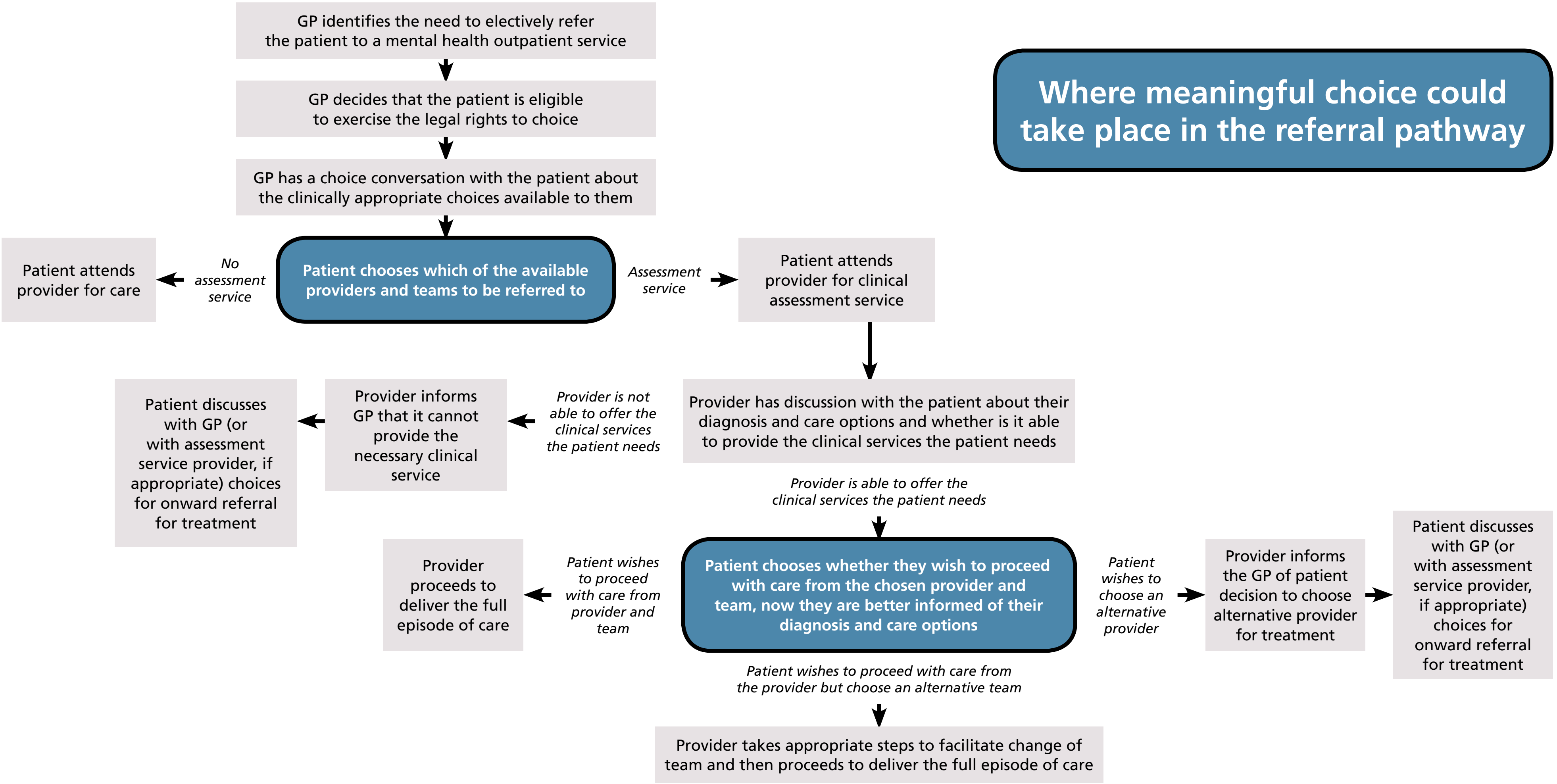
- clinical assessment services
- referral management centres
- single point of access.Given this variety, commissioners, providers and referrers will need to consider how the models in use will support patients to make choices about their provider and team at a point where those choices are meaningful.

Choice could become more meaningful if for example:

- a patient attends a single point of access and receives further information about their diagnosis or care options
- clinical assessment results in significant changes to the patient's diagnosis and/or care options.

Providers of clinical assessment services, referral management centres or single points of access must consider the need to offer patients their legal rights to choice and do so impartially. Wherever a patient's choice is clinically appropriate, providers are required to support the patient's decision in line with the requirements in the Commissioning Contract.

Where meaningful choice could take place in the referral pathway



GP identifies the need to electively refer the patient to a mental health outpatient service

GP decides that the patient is eligible to exercise the legal rights to choice

GP has a choice conversation with the patient about the clinically appropriate choices available to them

Patient chooses which of the available providers and teams to be referred to

No assessment service

Patient attends provider for care

Assessment service

Patient attends provider for clinical assessment service

Provider has discussion with the patient about their diagnosis and care options and whether is it able to provide the clinical services the patient needs

Provider is not able to offer the clinical services the patient needs

Provider informs GP that it cannot provide the necessary clinical service

Patient discusses with GP (or with assessment service provider, if appropriate) choices for onward referral for treatment

Provider is able to offer the clinical services the patient needs

Patient chooses whether they wish to proceed with care from the chosen provider and team, now they are better informed of their diagnosis and care options

Patient wishes to proceed with care from provider and team

Provider proceeds to deliver the full episode of care

Patient wishes to choose an alternative provider

Provider informs the GP of patient decision to choose alternative provider for treatment

Patient discusses with GP (or with assessment service provider, if appropriate) choices for onward referral for treatment

Patient wishes to proceed with care from the provider but choose an alternative team

Provider takes appropriate steps to facilitate change of team and then proceeds to deliver the full episode of care

For commissioners

Commissioning services

Commissioners are required to provide services that meet the reasonable needs of the populations for which they are responsible. In order to this they must determine what to commission for their population, and ensure that if a treatment/ service isn't routinely available, there are processes in place to enable the patient to receive that treatment/service, if agreed to by both the responsible clinician, and the individual funding request panel.

To support patient choice commissioners must ensure that arrangements are in place for providers, irrespective of whether they are public, independent or third sector organisations, to qualify and secure commissioning contracts for the provision of elective outpatient services that meet patients' needs. For this reason, it is not sufficient for a commissioner to do nothing more than recontract with existing qualified providers that are performing satisfactorily.

It is a statutory requirement for commissioners to secure the provision of clinical services, other than primary care, using NHS Standard Contracts. The terms of the NHS Standard Contract also provide commissioners with assurance that providers are obliged to meet high standards of quality and safety. Despite the requirement on commissioners to use the NHS Standard Contract, the legal right to choice extends to all clinically appropriate providers holding a contract with any NHS commissioner for provision of the service that a patient needs. Where a patient chooses a provider that is not commissioned using an NHS Standard Contract, commissioners should seek to put in place an NHS Standard Contract with that provider at the earliest possible opportunity.

Where a provider delivers an assessment/ triage service the commissioner should discuss with the provider how it will ensure that patients can exercise their legal rights to choice and should include relevant standards and reporting requirements within its contract with the provider.

Pricing and payment of mental health services

The National Tariff Document's mental health guidance10 includes the following:

- Payment rules for mental health services: these require the implementation of transparent payment approaches for mental health services for working age and older people, and adult IAPT. These approaches require consideration of the needs of patients and reward improved quality and outcomes in line with Five Year Forward View for Mental Health. The guidance also provides specific rules requiring new ways of paying for mental health services for working age adults and older people, and adult IAPT services.
- Support local change with guidance: supports commissioners and providers to make progress in implementing payment approaches that meet the payment rule requirements.
- Requirements and guidance on national data reporting: clarifies existing rules that require reporting of care clusters for Mental Health Services Dataset (MHSDS) and reference cost purposes, and requirements around data and information quality.

The National Tariff Document signals a clear move away from unaccountable block contracts and towards more transparent payment approaches that support improved quality and improvement in the outcomes that matter most to patients. Unaccountable block contracts do not facilitate a transparent understanding of the services being delivered, the outcomes achieved, or the costs of delivering effective services.

However, block contracts are not a reason for restricting a patient's legal right to choice of provider, as arrangements can be put in place to facilitate choice where block contracts are in operation. Arrangements should include commissioners working with providers to monitor the impact of the right to choice of provider on patient referral patterns. Where commissioners have block contracts with providers, and those contracts do not contain caps and collars, if numbers of referrals vary outside anticipated levels, commissioners may wish to seek a variation to contracts to help ensure that money follows the patient.

For services covered by the nationally mandated currencies, NHS Improvement and NHS England have recommended that all mental health commissioners and providers move to contracts that are based on anticipated cluster caseload.

Paying for mental health services

Where a patient chooses a provider with which their responsible commissioner holds a Commissioning Contract for the outpatient services required, payment should proceed as per current arrangements.

Where patients choose a provider with which their responsible commissioner does not hold a Commissioning Contract, the responsible commissioner will need to pay the provider, consistent with the Who Pays?11 guidance.

Pricing and payment of mental health services

As set out in Who Pays?11, non-contract activity is undertaken by the provider on the terms of the NHS Standard Contract in place between the provider and its main host commissioner. A contract on those terms will be implied as between the patient's responsible commissioner and the provider.

The provider should invoice the responsible commissioner for these services, in line with the normal requirements set out in Service Condition 36 of the NHS Standard Contract.

Consistent with the Guidance on mental health currencies and prices12, for non-contracted activity, the commissioner should expect to receive an invoice for any assessment and/or care provided.

Where they exist, daily cluster prices should be used. This will introduce consistency in charging and will reduce the need for lengthy negotiations between providers and commissioners about the price of non-contracted activity.

Reference costs for 2015/1613 are a source of indicative information, providing a breakdown of the reported costs of admitted and non-admitted care associated with each cluster, and the costs of a number of other specialist services.

Checklist for delivery

Commissioners have a responsibility for ensuring that patients' legal rights to choice of mental health service provider and team are upheld in the commissioning and delivery of services. The following checklist may help commissioners to ensure that they are discharging this responsibility.

Commissioning plan

☐ Publicly demonstrate how they are working within their local area to implement choice of mental health provider and team.

☐ Be clear about how they take into account patient preferences and how they change and emerge over time, when making decisions about which mental health services to commission.

Commissioning services

☐ Ensure arrangements are in place for both existing and new mental health services providers (public, independent and third sector) to qualify and secure contracts to provide services under a Commissioning Contract.

☐ Ensure that they take into account the National Tariff Document when putting in place contracts with providers.

Contract management

☐ Consider how they will utilise the Commissioning Contract to ensure that the mental health providers they contract with fulfil the requirements on them to support patient choice.

☐ Liaise with their local authorities to ensure that information is shared appropriately across organisations providing care to a patient.

☐ Ensure systems are in place to process non-contract activity invoices.

Referral protocols

☐ Make arrangements to ensure that, at the point of GP referral or after assessment, mental health patients in need of elective care are offered a choice of any clinically appropriate mental health service provider and team.

☐ Work with providers to ensure that choice is offered alongside clinical assessment services, referral management centres and single points of access.

☐ Inform GPs, and keep them updated, about the types of mental health services they routinely commission, since a GP referral constitutes authority to treat on behalf of the CCG.

☐ Approve providers' services on NHS e-Referral Service (e-RS), thereby allowing GPs to refer to the services on e-RS.

☐ Make arrangements to ensure that, when upholding any complaint that an eligible patient did not receive the legal rights to choice, the patient is then offered a choice of any clinically appropriate provider and team.

Information for patients

☐ Publicise patients' rights to choice.

☐ Inform patients where they can find information about mental health providers and teams in order to help them make choices.

☐ Inform patients how they can complain if they feel they have not been offered a choice or do not have access to information on which to base their choice.

For GPs

Assessing eligibility

‘The choice offer’ on page 4 of this guidance sets out which mental health patients, conditions and services are covered by the legal rights to choice, as well as those patients, services and circumstances for which the rights to choice do not apply.

Considerations for clinical appropriateness

It is for the GP to decide what is clinically appropriate when offering eligible patients their legal rights to choice.

Particular consideration needs to be given to clinical appropriateness where a patient has complex mental health needs and requires an integrated package of health and social care to avoid their care being fragmented.

When discussing clinically appropriate choices with patients, using the information available at the point of referral, GPs should consider:

Involving patients in decision making

☐ Discussing the patient's personal circumstances.

☐ Discussing the patient's continuity of care, for example any co-morbidities and existing care and treatment the patient is receiving or needs to receive.

☐ Discussing the patient's rights to choose the provider and team at the points at which the choice is meaningful.

☐ Discussing whether the patient would benefit from accessing an advocacy service.

☐ Discussing whether the patient would benefit from receiving further information in a more accessible format.

Provider services and outcomes

☐ Whether the provider offers evidence-based and effective care for the patient's condition.

☐ The quality and clinical outcome indicators for the providers' services.

☐ Patient and user feedback for the providers' services.

Clinical considerations

☐ Whether there is risk of fragmenting care through the choice that a patient wishes to make, for example where a patient requires a high level of integrated health and social care.

☐ Any implications patient choice of provider has for the delivery of crisis care should it be required during their episode of care.

☐ Whether the patient has been recently discharged and the potential clinical benefits of continuity of care.

Practical implications

☐ Discussing how the patient would be able to travel to and from the provider if the patient lives outside the area served by the provider.

☐ Any local provision for patient transport to and from their chosen provider.

Conflicts of interest

Where a non-primary care provider of mental health services has staff within a GP practice, either to provide advice on diagnoses and/or to administer care, the GP may seek their advice to help determine the patient's condition(s) and the type(s) of services that the patient needs. The mental health staff and the GP must however avoid any conflicts of interest in supporting the patient's choice of provider to deliver the care.

Where a non-primary care provider of mental health services to which the legal rights apply has staff co-located within a GP practice to administer care, the GP practice may not prevent or otherwise restrict patients from other GP practices accessing those services if patients exercise their legal right to choose to be referred to those services for their first outpatient appointment.

NHS e-Referral Service (e-RS)

e-RS is well established as the principal electronic means of referring patients to outpatient services, and is being increasingly used for referrals to mental health services. GPs need to support patients in making informed choice and e-RS allows GPs to view available providers, send referral information electronically to that chosen provider, and enable the patient to be booked into an appointment slot.

e-RS:

- can facilitate the choice conversation between GPs and patients
- includes a direct link to provider profiles on NHS Choices
- has the ability to support different referral pathways
- e-RS supports GPs in asking for advice and guidance before making a referral
- is secure and auditable for all users.

e-RS supports first elective referrals and the booking of adults, children and adolescents directly into an appointment, or to a mental health clinical assessment service, if required. Patients may be able to book their appointments while in the GP practice or later online or via the national Telephone Appointment Line (TAL).

Making an elective referral to a mental health service provider and team is broadly similar to an elective referral to any other service on e-RS. For new users of the system, the ‘Referring a Patient’14 e-learning tool available from the e-RS website gives a comprehensive step by step guide.

NHS e-Referral Service – Mental Health Services15 provides further guidance.

As with existing practice and where appropriate, GPs should ensure social services are kept informed of where the patient is being treated.

Assessment services

Clinical Assessment Services, Referral Management Centres and Single Points of Access

Where a clinical assessment service, referral management centre, or single point of access sits between the initial GP referral and the provision of care, it is important that the GP discusses this arrangement with the patient as it may have implications for the point at which the patient can make a meaningful choice. Suggestions about the points at which choice is meaningful can be found on pages 9-11.

The patient's rights to choice should be exercised at the point where the patient can make a meaningful choice about the provider and the team. If this occurs within the clinical assessment service, referral management centre, or single point of access the healthcare professionals having a choice conversation with patient should refer to the guidance on page 17 about supporting patients to make clinically appropriate decisions. In doing so providers must avoid any conflicts of interests7.

Further information

If a patient is receiving care from a provider or a team and the relationship breaks down this can result in the patient disengaging from care and can ultimately affect their likely clinical outcomes. If a patient is not happy with the service they are receiving they may discuss their concerns with a care professional. This may be with the provider in the first instance or the patient may return to their GP if for any reason they do not want to continue to receive care from their chosen provider. In which case, although the patient will not have a legal right to choose an alternative provider, the GP should discuss what is in the patient's best interests, and any other options available.

For Providers

Provision of mental health services

Mental health is a sector where there is already a wide range of providers. There is potential for changes in referral patterns across existing providers and for new providers to enter the sector over the coming years in response to patients exercising their rights to choice. Commissioners must provide appropriate opportunities for new providers to qualify for and secure a contract to deliver such services.

Supporting meaningful choice

The right to choice of provider should be exercised at the point where the patient is able to make a meaningful, informed choice.

Providers of clinical assessment services, referral management centres or single points of access must consider the need to offer patients their legal rights to choice and do so impartially.

Wherever a patient's choice is clinically appropriate, providers are required to support the patient's decision in line with the requirements in the Commissioning Contract16 and with the guidance on complying with with the choice and competition licence conditions7. Supporting meaningful choice should form part of discussions between the commissioner and the provider of the clinical assessment service, referral management service or single point of access.

Service information

Contractual requirements to make service information available

Meaningful and informed choice of provider for patients with mental health conditions depends on patients and GPs having access to good quality, up to date information from providers about the mental health services they offer. The Commissioning Contract requires providers to:

- describe and publish all relevant services (except high secure services) and associated appointment slots on e-RS
- make their service information available to the public on NHS Choices.

Mental health service providers who have a Commissioning Contract with a CCG or NHS England must meet these contractual requirements16.

NHS e-Referral Service

e-RS:

- can facilitate the choice conversation between GPs and patients
- allows providers to promote suitable mental health services online
- has the ability to support different referral pathways
- e-RS supports GPs in asking for advice and guidance before making a referral
- is secure and auditable for all users.

e-RS supports first elective referrals and the booking of adults, children and adolescents directly into an appointment, or to a mental health clinical assessment service, if required.

Service information

How to set up services on NHS e-Referral Service

The principles of setting up a mental health service are broadly the same as setting up any other service in e-RS.

Providers need to:

- decide which of their services are appropriate to publish on e-RS
- upload key clinical information for each service using Speciality/Clinic Types and SNOMED clinical terms (e.g. anxiety disorder)
- upload relevant information for each service about its single or multi-disciplinary teams, including information about the service's named healthcare professional(s).

Guidance and information17 to support providers in setting up their services on NHS e-Referral Service is available.

Some existing and prospective mental health providers do not yet have electronic systems that communicate directly with e-RS.

They are still able to list their services on the e-RS system, but the booking of appointments requires manual intervention.

All mental health providers should therefore be able to make the necessary information about their services available to help patients and their GPs choose a clinically appropriate service to meet the patient's needs. Further guidance is available in NHS e-Referral Service - Mental Health Services15.

Integrated care

To secure best outcomes many patients will need interventions from a range of health and social care professionals working together across organisational and geographical boundaries. Providers will currently have systems in place to support delivery of care for out of area patients, and where necessary these should be utilised to enable delivery of high quality care to patients who have exercised their legal right to choice.

The Commissioning Contract (Service Condition 4)16 requires providers to co-operate with others and have due regard to the welfare and rights of patients including having a duty to ensure that a patient's care remains integrated. Where a patient's choice of provider has practical implications for any wider package of care the patient might be receiving, or needs to receive, or the patient's choice raises issues about patient safety, the provider should discuss this with the patient and contact the referring GP to discuss and agree an appropriate way forward.

Sharing patient information between organisations

A key source of information for providers, which includes links to further guidance is Information: To Share or not to Share Government Response to the Caldicott Review18

When regular exchanges of information need to take place between different agencies it is important to have a formal agreement in place to ensure that everyone understands what information will be exchanged, for what purpose, and to whom.

Crisis care

Some patients with mental health conditions are more at risk than others of experiencing a crisis. Crisis might happen during the course of elective outpatient care. It is important that wherever patients receive crisis care, the provider of that care can access up to date information about the patient and any elective care they have been receiving.

The Mental Health Crisis Care Concordat6 was published in February 2014 and aims to improve the system of care and support so people in crisis are kept safe and helped to find the support they need. People should be helped to receive that support whatever the circumstances in which they first need help and from whichever service they turn to first.

Receiving referrals

Providers should accept referrals that are made to them through the exercise of patients' legal rights to choice, in line with the conditions set out in the Commissioning Contract. Once a referral has been accepted the patient must be treated by that provider for their entire episode of care.

If a patient's diagnosis changes significantly the provider should contact the patient's GP to discuss whether it is still clinically appropriate for the patient to be treated by that provider and whether the commissioner will continue to fund the episode of care.

Pricing and payment of mental health services

The National Tariff Document's mental health guidance10 includes the following:

- Payment rules for mental health services: these require the implementation of transparent payment approaches for mental health services for working age and older people, and adult IAPT. These approaches require consideration of the needs of patients and reward improved quality and outcomes in line with Five Year Forward View for Mental Health. Specific rules require new ways of paying for mental health services for working age adults and older people, and adult IAPT services.
- Support local change with guidance: supports commissioners and providers to make progress in implementing payment approaches that meet the payment rule requirements.
- Requirements and guidance on national data reporting: clarifies existing rules that require reporting of care clusters for Mental Health Services Dataset (MHSDS) and reference cost purposes, and requirements around data and information quality.

The National Tariff Document10 signals a clear move away from unaccountable block contracts and towards more transparent payment approaches that reward improved quality and improvement in the outcomes that matter most to patients. Unaccountable block contracts do not facilitate a transparent understanding of the services being delivered, the outcomes achieved or the costs of delivering effective services. However, block contracts are not a reason for restricting a patient's legal right to choice of provider, as arrangements can be put in place to facilitate choice where block contracts are in operation.

Arrangements should include providers and commissioners working together to monitor the impact of the right to choice of provider on patient referral patterns. Where block contracts are in place, and those contracts do not contain caps and collars, if numbers of referrals vary outside anticipated levels, commissioners may wish to seek a variation to contracts to help ensure that money follows the patient.

For services covered by the nationally mandated currencies, NHS Improvement and NHS England have recommended that all mental health commissioners and providers move to contracts that are based on anticipated cluster caseload.

Charging for mental health services

Where a patient chooses a provider that has a Commissioning Contract with the patient's responsible commissioner, payment should

Pricing and payment of mental health services

proceed as per current arrangements.

Where patients choose a provider that does not hold a Commissioning Contract with the patient's responsible commissioner, the provider will need to charge the responsible commissioner, consistent with the Who Pays? guidance?11. The provider should invoice the patient's responsible commissioner for these services, as they would for any other non-contracted activity. Non-contract activity is undertaken by the provider on the terms of the Commissioning Contract which is implied as between the patient's responsible commissioner and the provider.

Who Pays?11 clarifies the general arrangements for services provided as non-contract activity and sets out how providers should invoice for such activity. There is specific guidance on mental health currencies and prices12 which includes a section on choice and non-contract activity. Using the principles set out in this document, where a provider receives a non-contracted activity referral through the exercise of the legal right to choice, the provider should use the following charging process:

- Separate out any assessment, non-admitted and/or admitted care that has been provided for the patient.
- Charge for the assessment and add the appropriate daily cluster price (or locally agreed alternative) per patient per day.
- Invoice the patient's commissioner on a monthly basis.

Where any emergency, urgent or crisis intervention is required from a provider with whom the responsible commissioner does not have a contract, the commissioner will be expected to fund this as non-contracted activity, in line with the Who Pays?11 guidance.

How mental health services are priced

When charging for non-contracted activity, daily cluster prices should be used, where they exist. The process for calculating these cluster prices can be found in the NHS Improvement and NHS England guidance on mental health currencies and prices12.

Reference costs for 2015/1613 are a source of indicative information, providing a breakdown of the reported costs of admitted and non-admitted care associated with each cluster, and the costs of a number of other specialist services.

NHS England suggests that where a patient requires services that are not included or specified within an existing priced cluster, the price the provider should charge the responsible commissioner should be calculated in a manner that is consistent with the principles of the National Tariff for local prices, particularly under section 6 of

Pricing and payment of mental health services

the National Tariff Document's mental health guidance10.

Charging for crisis care

The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis6 sets out an effective approach to ensuring people experiencing mental health crisis can access the support they need, when they need it.If the patient seeks crisis care from a provider with whom the responsible commissioner does have a Commissioning Contract, payment should proceed as per current arrangements.

If a patient seeks crisis care from a provider with whom the responsible commissioner does not have a Commissioning Contract, the commissioner will be expected to fund this as non-contracted activity, in line with the Who Pays?11 guidance. The provider should assess the patient and then assign the patient to the appropriate cluster. The provider should then proceed to invoice the commissioner as set out above.

Disagreement on payments

Commissioners and providers should work together in good faith to minimise disagreements relating to payment for non-contract activity. Any formal disputes over payment for non-contract activity should be resolved in accordance with the dispute resolution procedure set out in the Commissioning Contract.

Checklist for delivery

Providers have a contractual responsibility for ensuring that patients' legal rights to choice of mental health service provider and team are upheld, in line with the Commissioning Contract. The following checklist may help providers to ensure that they are discharging this responsibility.

Facilitating the exercise of legal rights to choice

☐ Accept all clinically appropriate referrals in line with the Commissioning Contract.

☐ Liaise with the patient's GP where the provider considers the referral clinically inappropriate.

Supporting meaningful choice

☐ Consider how choice will be offered alongside any clinical assessment service, referral management service or single point of access the provider delivers.

☐ Comply with guidance regarding licence conditions7

☐ Provide staff with the appropriate information and training to enable them to hold a meaningful choice conversation with patients.

Making service information available

☐ Describe and publish all primary care referred services in the e-RS through a Directory of Service.

☐ Publish up to date service and team information on NHS Choices.

Supporting integrated care

☐ Ensure systems are in place to facilitate information sharing with the organisations relevant to a patient's care, including where these organisations are not local.

☐ Consider putting in place additional information sharing arrangements where appropriate.

☐ Keep the patient's GP informed of relevant aspects of the patient's care.

Charging for services

☐ Price services delivered as non-contracted activity in line with the National Tariff guidance.

☐ Comply with requirements for information reporting and information quality.

☐ Invoice the responsible commissioner on a monthly basis, clearly stating prices for assessment and the appropriate daily cluster price (or locally agreed alternative) per patient per day.

Programme of further work

Embedding the legal rights to choice

The aim is to embed these legal rights, so that they operate well and in the best interests of patients. This means that:

- All patients with mental health conditions are aware of their rights, and have the information and support they need to make well informed choices that meet their needs and preferences.
- All GPs offer choice to eligible patients and support them in making informed decisions.
- All providers of mental health outpatient services make good quality, up to date information about their services available to enable meaningful choice by patients, and accept all appropriate patient referrals, in line with their Commissioning Contract.
- All commissioners enable the right to choice of services by:
  - commissioning services that meet the needs of patients
  - having referral protocols with GPs that support patient choice
  - using the levers in the Commissioning Contract to ensure choice works well for patients.

Embedding the legal rights to choice in mental health will take time and effort to achieve. This guidance is part of a significant programme of work that will support the implementation of the legal rights. Details of this programme of work are available on the NHS England website19.

As part of this programme of work, additional resources to help support the implementation of the legal rights to choice, are available on the NHS England website19. There will be ongoing engagement with stakeholders as the programme progresses and additional supporting resources will be coproduced and added to the website.

FAQs

Where the rights apply

Mental health patients and the circumstances in which they have a right to choice.

Q1: Do patients have a right to choice of clinically appropriate provider and team in circumstances where their mental capacity is impaired?

A: Patients should be involved as much as possible in decisions about their care. However, across the range of mental health conditions that patients might experience, patients may be vulnerable and their ability to exercise choice that is clinically appropriate could be compromised. All issues relating to mental capacity should be decided with reference to the Mental Capacity Act (MCA) 20059 and its Code of Practice. Under the Act, all referrers are required to support their patients in making decisions about their care, including patients with a mental impairment.

Patients aged 16 or over are assumed to have capacity to make their own decisions, including decisions relating to their healthcare. If all practicable steps have been taken to help a person to make their own decision, and the person is assessed to lack capacity in accordance with the MCA, then care decisions in the person's best interests may be made for them.

The Mental Capacity Act 2005 (Code of Practice)20 provides guidance on making decisions for people who are assessed to be lacking the capacity to make such decisions for themselves (see chapter 2 of the Code of Practice).

There are a number of sources of guidance on the law concerning consent to physical examination and treatment. The Department of Health's Reference Guide to Consent for Treatment or Examination21 provides further advice on considering a person's mental capacity when obtaining consent to treatment.

The General Medical Council guidance on consent, Consent: patients and doctors making decisions together22 and the British Medical Association's Consent Tool Kit23, also provide useful guidance on making decisions about medical examination and treatment for people who lack capacity to make those decisions for themselves.

Where the rights apply

Q2: Do patients have a legal right to choice of clinically appropriate provider and team when detained in a secure ward?

A: No. Patients who are sectioned under the Mental Health Act 1983 do not have legal rights to choice of provider or team, therefore any patient detained under the Act would not be eligible to exercise their legal rights to choice.

Q3: Do patients have a legal right to choice of clinically appropriate provider and team when being admitted to a locked acute ward?

A: No. The legal rights to choice of provider or team do not apply to inpatient services.

Q4: Do children and young people have the right to choice of clinically appropriate provider and team for their mental health care?

A: Patients aged 16 or over are assumed to have capacity to make their own decisions, unless there are grounds to suggest otherwise. If a patient is under 16 the GP should assess their Gillick competency and take a decision, with the patient, about their ability to make an informed choice. If the child is Gillick competent the GP should still include the child's parents or guardians in their choices. If the child refuses, and the child's well-being depends on their choices, and it is in their best interests to proceed without parental involvement, the GP should proceed accordingly (the 'Fraser Guidelines'). Where a young person, aged 16-17, has capacity under the Mental Capacity Act but is unable to make a decision because they are overwhelmed by its implications, the GP should involve the patient's parents or guardians. If the patient is under 16 and is not Gillick competent then the patient's parents or guardians may exercise choice on their behalf.

Children and young people should be kept as fully informed, just as an adult would be, and should receive clear, detailed information concerning their care, explained in an age-appropriate way they can understand. The Department of Health's Reference Guide to Consent for Treatment or Examination21 provides further advice on when children and young people can consent to treatment and therefore make decisions about their own care. The General Medical Council's 0-18 Years: Guidance for all doctors24 and the British Medical Association's Consent Tool Kit23, also provide useful guidance on helping children and young people make valid consent decisions about their treatment.

Q5: Are learning disability services included in the legal rights to choice?

A: Yes. As long as the services meet the criteria set out in legislation then patients have a right to choose their learning disability provider and team.

Where the rights apply

Q6: Do patients have a right to choice if they require integrated health and social care?

A: Patients are eligible for choice of mental health provider and team including where they require integrated packages of care involving social care. Patients should discuss their options with their GP to ensure that their choices are clinically appropriate to meet their needs and preferences and to ensure that care can continue to be delivered in an integrated way that is effective in meeting their needs.

Q7: Do patients have a right to choose independent or third sector providers?

A: Yes. Patients have a right to choose any clinically appropriate mental health service provider, including an independent or third sector provider that has a Commissioning Contract with any CCG in England or with NHS England for the provision of the required services.

Q8: Is choice of provider and team compatible with personal health budgets?

A: Yes. As part of receiving a personal health budget, patients can choose to receive clinical services from any provider, including those who are not currently commissioned by a CCG or NHS England. This does not need to be agreed by an Independent Funding Review Panel but must be agreed by the party responsible for approving personal health budget plans within the patient's CCG. CCGs should be in a position from April 2015 to offer personal health budgets to eligible individuals that would benefit from one. Further information is available on the personal health budget web page5.

Q9: What happens if a patient is not happy with the provider or team they have chosen: do they have a legal right to make further choices?

A: No. But, if a patient is not happy with the service they are receiving they may discuss their concerns with a care professional. This may be with the provider in the first instance or the patient may return to their GP if for any reason they do not want to continue to receive care from their chosen provider. In which case, although the patient will not have a legal right to choose an alternative provider, the GP should discuss what is in the patient's best interests, and any other options available. Ultimately, if still not satisfied, the patient may choose to make a complaint through the NHS Complaints Procedure25.

How the rights work

Q10: What should patients do if they are not offered their legal right to choice?

A: GPs should ensure that patients are aware of their choice options and that eligible patients are offered the choices to which they are entitled. However, if choice is not offered, the NHS Choice Framework26 provides information on the steps that patients can take. Patients should contact their local CCG in the first instance. Ultimately, if still not satisfied, the patient may choose to make a complaint through the NHS Complaints Procedure25.

Q11: Do the legal rights to choice apply only to those services for which the 18 week referral to treatment standard applies?

A: No. The legal rights to choice apply to all elective outpatient services led by a consultant or healthcare professional. Further details are outlined on pages 5-7. legislation then patients have a right to choose their learning disability provider and team.

Out of area referrals

Q12: Who meets the travel costs for patients attending outpatient appointments?

A: The NHS travel costs guidance Healthcare Travel Costs Scheme: Instructions and Guidance for the NHS27 provides further information on the support available for the travel costs of people on low incomes.

Q13: Would patients exercising their legal rights to choice of provider and team wait longer for treatment?

A: All patients, whether accessing services through their legal right to choice or through standard, local referral protocols, should be treated equally with regards the time they wait to access services.

Mental health providers should provide waiting time information about their services on NHS Choices so that patients and GPs may take this into account when patients choose which provider they want to attend for their first outpatient appointment. e-RS shows the indicative waiting time for first outpatient appointments which can help patients and GPs make a more informed choice.

Q14: Should commissioners allow referrals to providers which offer an equivalent but more expensive service than those routinely contracted by the patient's CCG?

A: Yes. Details on calculating the price to charge the responsible commissioner are on page 29.

Q15: If so, who pays?

A: The commissioner responsible for the patient pays. The guidance document Who Pays?11, clarifies the general arrangements for payment of services provided as non-contract activity.

Changes in referral patterns

Q16: What should commissioners and providers do if changes to patient flows decrease to the point of making some services unsustainable?

A: It is unlikely that changes to patient flows resulting from the introduction of choice in mental health will be the primary reason for a service becoming unsustainable. Services should be designed around the needs of local communities and strive to achieve and demonstrate the best quality and patient outcomes. Where patients experience high quality local services, we do not anticipate significant changes in patient flows.

Mental health providers should provide quality, outcomes and waiting times information about their services on NHS Choices so that patients and GPs may take this into account when patients choose which provider they want to attend.

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4. **As set out in the Standing Rules (see endnote 3) the legal rights apply to elective referrals made by a general medical practitioner, general dental practitioner or optometrists (Regulation 38). Of these, referrals to mental health services will be made by GPs so this term is used throughout this guidance.**

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Further resources

Additional supporting material is available on the NHS England website. Please visit:
www.england.nhs.uk/ourwork/pe/patient-choice/

A country that works for all children and young people

An evidence-based plan for addressing the autism assessment and support crisis

Child of the North
N8 RESEARCH PARTNERSHIP
HEALTH EQUITY NORTH
CENTRE FOR YOUNG LIVES

Contents

Foreword by Anne Longfield and Camilla Kingdon

A growing number of children and young people (CYP) are being diagnosed as autistic. The most recent government estimate is that almost 2% of pupils in England now have an autism diagnosis, a number that has risen over recent years as awareness about autism has increased. Autistic CYP experience the world in a different way which can have an impact on social communication and interaction, interests, and can be characterised by restricted or repetitive behaviours. Autistic CYP may also have different ways of learning, moving, or paying attention.

These factors can have a profound impact on the daily life of autistic CYP and their families, and most will face some challenges as they grow up. The education system can be difficult for some autistic CYP, particularly those at schools with very rigid policies. Only a quarter of autistic CYP say they feel happy at school – and it is perhaps unsurprising that an autistic CYP is twice as likely to be excluded from school as a child without Special Educational Needs or Disabilities (SEND).

Most autistic CYP – and their families – need some health service and other support as they grow up. Too often the gateway to receiving that support is complex. It requires an assessment to take place, yet as this report sets out, the UK has an autism assessment crisis. Thousands of CYP who need an autism assessment and support are not receiving timely help. As one parent seeking an assessment for her child told the report authors, “it was an absolute nightmare”.

Many thousands of families feel the same way, and they are being left to navigate a support system that is hampered by processing delays and long waiting lists. On average, only one in 10 CYP are receiving an appointment within 13 weeks of being referred, and as the statistics in this report show, girls and children from ethnic minority groups are even less likely to receive the support they need.

This failure to provide the right autism support can lead to poor long-term outcomes for autistic CYP, including an increased prevalence of connected conditions such as mental ill health.

As anyone who has worked with CYP in an education or secure setting knows, there can be huge costs and consequences of failing to support autistic CYP – reduced life chances, a higher risk of school exclusion or not attending school, and in the very worst cases a greater risk of harm, exploitation, or criminalisation.

The systems for those autistic CYP who do need health service support need to be transformed, and the way assessments are delivered and how information is shared needs urgent reform. As well as improving life chances, tackling this autism assessment crisis could have a beneficial knock-on effect to the wider education, health, criminal justice systems, and reduce some of the enormous current financial pressures on those services.

This report sets out how change can happen. It has been produced by eight research-intensive universities in the North of England – the N8 Research Partnership – combined with a wider academic community (the N8+) as part of the Child of the North initiative, and the new Centre for Young Lives thinktank. It is the first in a series of 12 Child of the North/Centre for Young Lives reports to be published during 2024, which together will look at how we can encourage government to reset its vision for CYP.

The series of reports will show how putting the interests and life chances of CYP at the heart of policymaking and delivery is crucial to Britain’s future. They will shine a light on some of the biggest challenges facing government, including reducing child poverty, and improving support for CYP with mental health conditions, while also providing rigorous research and pragmatic, evidence-based recommendations which acknowledge the ongoing financial limitations on government spending.

As we approach the next general election, there is no better time to make the case for changing the Government’s overall approach to improving the lives of CYP and families, whichever political party is in power.

Since the COVID-19 pandemic, there has been a **306%** increase in the number of children waiting for an autism assessment.

The series begins with this analysis of the current system of support for autistic CYP. It reveals that while we are spending large amounts on the system, and despite the publication of the Government's autism strategy in 2021, the autism assessment crisis is continuing to worsen. Waiting times for assessment have soared since the COVID-19 pandemic and the number of CYP accessing autism services is now at a record high. This is a system under unsustainable pressure.

In July 2022, more than 125,000 people were waiting for an autism assessment by mental health services, an increase of 34% since October 2021. By July 2023, this number had risen to more than 143,000. Figures published in September 2023 show there were 157,809 patients with an open referral for suspected autism.

On average, one out of 10 CYP are still to receive an appointment 13 weeks after their referral.

More than one in four parents have waited over three years to receive support for their child.

The evidence shows that early identification and support is crucial. CYP with autism and related issues, such as attention-deficit hyperactivity disorder (ADHD), can thrive in mainstream education if their needs are identified early. Instead, too many autistic CYP are being left without an assessment, and without early help, partly because the system places so much emphasis on assessment before support is provided. Too many CYP are not receiving the help needed in school without first receiving a medical diagnosis.

Yet autistic CYP are at significantly greater risk of both social and school exclusion, and the group at greatest risk are those with a referral who are awaiting assessment. As waiting times increase, so will the risk of increased exclusion and poorer educational outcomes for these children. Some will end up in Alternative Provision (AP) – with its associated higher costs and generally lower academic outcomes – because they haven't received support earlier in their school life. This is particularly frustrating given the evidence shows that when support is in place following a diagnosis, autistic CYP are less likely to be excluded.

We must move towards a needs-led approach, rather than just relying on a diagnosis-led system. Early identification and support, rather than waiting for a diagnosis, will lead to better long-term outcomes and reduce costs. As this report argues, improved information-sharing between the health and education systems and a more coordinated approach to support, including early help in nurseries and schools before formal diagnosis, is essential.

Education settings can play such a major role in identifying and supporting autistic CYP, flagging CYP with a high likelihood of undiagnosed autism, and providing an environment for autism assessment. Health services can help schools prioritise children with increased likelihood of needing additional support. Government should be helping health and education systems to share information by using the NHS number as a single unique numerical identifier across public service records.

As this report highlights with existing examples of good practice, the development of genuine formal partnerships at local authority level between health and school services and nurseries, and voluntary services, faith groups, universities, and businesses, is key to tackling the autism assessment crisis and creating autism-friendly environments. Government has a vital role to play in ensuring this coordination happens, although expecting Whitehall to solve this crisis will not be enough on its own.

Bradford has shown how creating its own database of primary and secondary healthcare records across the District that links with education, social care, and policing data produces a powerful research tool that reveals the social issues facing different services. So, we now know that 77% of CYP diagnosed with autism in Bradford are male, and that large numbers of girls in Bradford are not being identified (a nationwide problem, as this report also makes clear). This analysis also confirms there are significant and troubling ethnic inequalities in autism diagnosis.

The report makes a powerful case for how education data can identify autistic CYP "falling under the radar", how autism assessments can be conducted successfully in schools, and how better training of education and health professionals can improve the needs of autistic CYP. It also stresses the importance of national and local political leadership to drive coordinated, whole system public service delivery at a local level.

Too many autistic CYP are being held back because our institutions are failing to provide an autism-friendly environment, and the system to provide the support they need isn't working. One parent told our focus group that Children's Mental Health Services admitted to her that they were in crisis and letting her child down, urging her in desperation to write to her MP. This is no way to run a support system for some of our most vulnerable CYP. Without urgent reform, we cannot hope to improve the life chances of the next generation. As this report shows, change is possible – and it is happening in some schools and local areas already. What is needed now is the determination from government and others to make it happen everywhere.

Anne Longfield CBE,
Executive Chair of
the Centre for Young Lives

Dr Camilla Kingdon,
President of the Royal College
of Paediatrics and Child Health

This report is a collaborative programme of work between Child of the North and the Centre for Young Lives.

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A full list of authors and contributors can be found at the end of the report.

A note about language

"Autistic person" vs "person with autism"

Following extensive PPIE work, autism-first language is used throughout this document, i.e., "autistic person" rather than "person with autism", as this moves us toward understanding autism as an integral part of an individual's identity rather than an additional "condition". While further research is needed to understand how we should talk about autism in a way that reflects the preferences of all autistic people (e.g., speaking and non-speaking, with and without intellectual disability), current guidance from autistic advocates suggests a preference for autism-first language [1, 2].

Schools, nurseries, and educational settings

Please note that this report often uses "schools" as shorthand for "schools, nurseries, and other educational settings such as pupil referral units and special schools". One central message of this report is the need for a "whole system" approach that includes all relevant stakeholders, and this includes all parts of the education system. We highlight that special schools have limited spaces, meaning CYP who require the support of special schools are in mainstream education, where the current special educational needs support available cannot meet the growing demand.

About Child of the North

Child of the North is a partnership between the N8 Research Partnership and Health Equity North which aims to build a fairer future for children across the North of England by building a platform for collaboration, high quality research, and policy engagement. @ChildoftheNort1

About the N8 Research Partnership

The N8 Research Partnership is a collaboration of the eight most research-intensive Universities in the North of England: Durham, Lancaster, Leeds, Liverpool, Manchester, Newcastle, Sheffield, and York. Working with partner universities, industry, and society (N8+), the N8 aims to maximise the impact of this research base by promoting collaboration, establishing innovative research capabilities and programmes of national and international prominence, and driving economic growth. www.n8research.org.uk @N8research

About Health Equity North

Health Equity North is a virtual institute focused on place-based solutions to public health problems and health inequalities across the North of England. It brings together world-leading academic expertise, from the Northern Health Science Alliance's members of leading universities and hospitals, to fight health inequalities through research excellence and collaboration. www.healthequitynorth.co.uk @_HENorth

About the Centre for Young Lives

The Centre for Young Lives is a new, dynamic and highly experienced innovation organisation dedicated to improving the lives of children, young people, and families in the UK – particularly the most vulnerable. Led by former Children's Commissioner, Anne Longfield CBE, who has been at the forefront of children's issues for decades, the Centre's agile team is highly skilled, experienced, and regarded. It is already widely known and well respected across government departments, Parliament, local and regional government, academia, the voluntary sector, and national and local media. The Centre wants to see children and young people's futures placed at the heart of policy making, a high priority for Government and at the core of the drive for a future for our country which can be much stronger and more prosperous. www.centreforyounglives.org.uk

Quotations

The illustrative quotations throughout the report were taken from extensive qualitative work with children, families and professionals in the North of England conducted by Danielle Smith [3], Emily Chapman [4], and Leanne Rogan [5] as part of their Doctorate in Clinical Psychology.

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Key insights

Prevalance and wait times

The number of children accessing autism services is at a record high.

As of September 2023...

↑46% Increase in closed autism referrals in the last year

↑27% Increase in new autism referrals in the last year

>93% Of children did not receive an appointment within 13 weeks of being referred

The number of children still yet to receive an appointment after 13 weeks has increased by...

↑36% Since COVID-19

↑21% In the last 12 months

Ethnicity

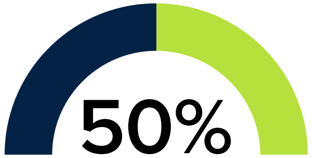
Structural inequalities in autism pathways hinder the chances of children from ethnic minority backgrounds accessing timely support.

GIRLS OF ASIAN HERITAGE HAVE:

3X Decreased odds of receiving an autism diagnosis compared to males

2X Decreased odds of receiving an autism diagnosis compared to children of white heritage

Children of white heritage are 50% more likely to receive an autism diagnosis compared to children of Asian heritages



306%

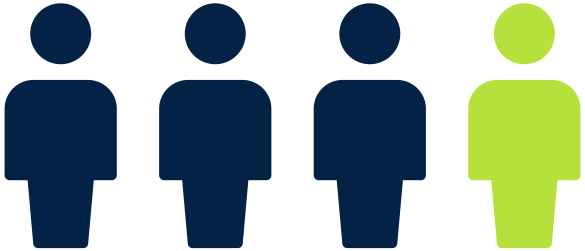
Increase in the amount of children waiting for an autism assessment since the COVID-19 pandemic

School

Autistic children face additional barriers in the school environment.

2X Autistic children are **2X** as likely to be excluded from school compared to non-SEND children

ONLY 26% Of autistic children feel happy at school



3 in 4 parents said their autistic child's school did not fully meet their needs

Gender

Autism can present differently in girls, meaning many children's needs can go unnoticed.

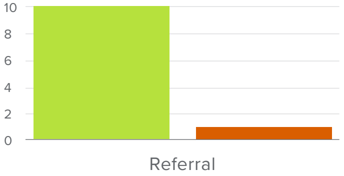
75%

Of autistic girls are estimated as being unidentified

Of the girls who are identified and assessed, a further **20%** are missed

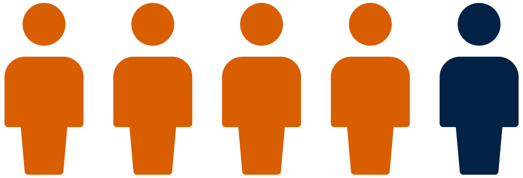
Boys are referred for a diagnostic assessment.

10X More frequently than girls



Physical & mental health

Autism is associated with poor mental and physical health.



4 IN 5 Young autistic people have co-occurring mental health conditions

Autistic people have a shorter life expectancy by up to...

30 YEARS

Defining autism and associated developmental differences

Autism is not an illness or disease – it is a term used to describe people with a specified collection of behavioural characteristics. The World Health Organization categorises autism as a "neurodevelopmental disorder" within its International Classification of Diseases (ICD-11) [6]. ICD-11 is the framework used within UK healthcare to diagnose autism. In the USA, the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is used instead, but there are only minor differences between ICD-11 and DSM-5, with some UK services using DSM-5 criteria in practice.

Healthcare professionals diagnose autism using tools that standardise observations of how someone behaves in a particular situation. These behaviours relate to difficulties with communication or social interactions; repetitive or restrictive behaviours; sensory differences (e.g., sound, vision, touch, taste, smell, temperature); and highly focused interests. It is important to emphasise that the observed behaviours lie on a continuum, with large proportions of the population exhibiting such characteristics. The diagnosis is therefore based on a clinical threshold where the behaviours are deemed to be occurring to an extent that warrants specialist healthcare support.

National Health Service England (NHSE) outline four major advantages to this approach: (i) it enables clinicians to recommend interventions that have been tested for safety, acceptability, efficacy, and effectiveness with people who face similar challenges within society; (ii) it ensures reasonable adjustments are made in general physical or mental health services (given the association between autism and the increased risk of poor general health); (iii) it helps develop a positive autistic self-identity and foster connections with the autistic community; (iv) it facilitates access to some forms of statutory protection beyond the healthcare context [7]. There are three critical points to make in the context of the above. First, children are constantly developing, and upstream experiences will shape their behaviours at an older age. This means that a child provided with adequate support at an early age may not subsequently need specialist healthcare intervention. Second, many children will not reach the clinical threshold, but will still need support. Third, the need for specialist healthcare does not imply that the responsibility for support falls on healthcare alone. The goal must be for appropriate support to be provided within homes and educational settings.

There is a danger that children who have autistic traits but do not reach clinical diagnostic thresholds fall into the gaps between health and education [8]. The World Health Organization’s (1980) International Classification of Functioning, Disability and Health (ICF) provides a useful framework for considering an individual’s functional abilities within the context of their nursery or school environment. The ICF defines disability as the inability to participate and engage in activities of daily living (which for children includes educational activities). The ICF emphasises that neurodevelopmental differences (albeit unhelpfully described as “impairments”) can cause disability if the environment (or activities) are not modified to accommodate these differences. This serves as a useful reminder that a child’s “disability” can be removed or decreased by adjusting activities and the classroom environment, regardless of a formal diagnosis.

There is a need for a shared understanding of the intersections between the ICD-11 and the ICF and how they can be better used to identify the specific role of health (ICD-11) and schools (ICF) in supporting autistic CYP.

The terminology for autism has evolved. Currently, some of the language adopted in international and national legislation is unhelpful and does not reflect the language preferred by those with lived experience [9]. Nevertheless, it is **necessary to recognise the existing legislative terminology when discussing system reform to avoid confusion** (noting that this does not preclude a change in terminology in the longer term).

Autism policy recommendations

The evidence is clear: human society can meet complex challenges through a concerted, collaborative effort to address a well-specified problem (from splitting the atom to the COVID-19 vaccine) [10]. To facilitate the UK in its mission to improve autism health service support in a systematic and scientific manner, we make three evidence-based recommendations.

> “You’re blocked from accessing services until you get that [diagnosis]… **parents are forced down this route.”**
>
> - Parent of an autistic young person

1

Build effective partnerships between education and health professionals for assessing and supporting autistic children. This should include delivering assessments in education settings and making a holistic offer of support in schools and nurseries before and after a formal diagnosis is made.

The evidence is clear – educational settings can play a major role in identifying and supporting autistic CYP. Education data, specifically data routinely collected through the Early Year Foundation Stage Profile (EYFSP), can flag children with a high likelihood of undiagnosed autism, often at an earlier age than is possible via health routes [11]. Autism assessments can be conducted efficiently in education settings [3, 12]. Meanwhile, health information can help schools and other educational settings prioritise children with increased likelihood of needing additional support. The exchange of information and genuine partnerships between health and education services can offer a more effective and efficient approach to assessment than the current model. Adopting this approach could begin to reverse the autism assessment crisis and reduce the structural inequities revealed by the research. A coordinated approach could allow children’s needs to be supported before a formal diagnosis has been made.

2

Provide and extend access to mandatory Continuing Professional Development (CPD) courses for health, education, and social care professionals that improve understanding and awareness of autism (and related issues). These courses should include information on how to create “neurodiverse friendly” environments, and particularly raise awareness of autism in girls and ethnic minority groups. Additional training should be co-produced by individuals with lived experience, delivered to professionals, and integrated into undergraduate health and education professional training, to improve the identification of autistic girls.

The evidence is clear – structural inequity can be seen in autism assessment so girls, ethnic minorities, and lower socioeconomic groups receive support later than their peers (see “Inequity must be addressed in autism pathways” section) [13]. The evidence suggests that improving awareness across professionals could address some of these issues and accelerate the creation of autistic led and coproduced health and education provision [3, 14]. Inclusive spaces are characterised by flexibility, whereby reasonable adjustments are made with the potential to benefit everyone [15]. Schools and colleges should measure success in this area by reporting on attainment, attendance, elective home education rates, exclusion, and suspension for autistic CYP.

3

Create formal partnerships at a local authority level comprising sector leaders (including schools, health, voluntary services, faith, universities, educational psychologists, and businesses) to oversee a prioritised governmental ward-level approach to addressing the autism crisis. The partnership should focus on its most disadvantaged wards and provide leadership in trialling data-driven, community and family co-produced, “whole system” approaches to improve autism support with and through education settings.

The evidence is clear – the complex needs of autistic CYP and their families need public services, businesses, and the voluntary sector to collaborate and create “autism-friendly” places [16]. The creation of autism-friendly places, such as sensory rooms, must be tailored to the cultural backdrop of an area. The evidence suggests this is best achieved at the ward-level and this, in turn, allows a strategic approach to addressing inequity [17]. The “Integrated Care Systems” (42 systems across England responsible for delivering health and social care services) provide an outstanding opportunity to implement such approaches supported by the Core20PLUS5 NHS inequality initiative [18].

These recommendations have resource implications but offer immense potential for decreasing the long-term costs associated with not acting early (i.e., the health, social care and criminal justice bill that results from not supporting children’s needs); they will help the UK benefit from the economic growth available if the autistic population’s talents were deployed within the workforce.

Principles

The evidence on current autism support across the UK paints a compelling and worrying picture: there is an urgent need for the UK to transform its support systems for autistic CYP and their families. We cannot keep doing more of the same (e.g., throw some additional resource at conducting a few more assessments in hospitals to reduce autism waiting list times – a costly approach tried many times, in many places, with no lasting impact). We need a radical overhaul of our approach to supporting autistic CYP and – most critically – to trial new approaches that better connect health and education.

Overview

The recommendations within this report relate to the population of autistic CYP who have needs that require specialist medical support. A future report will address the wider population who require additional special education support but do not meet the clinical threshold for specialist healthcare intervention.

The evidence shows that the problems affecting autism healthcare pathways are complex – where complexity is defined as an inability to address the problem through action in a single component part of the system [19]. It follows that successful solutions will transcend the NHS and involve multiple stakeholders working in partnership with affected CYP and their families. Central and local government have a necessary role to play in connecting, coordinating, supporting, and challenging systems, but government action alone is insufficient. The time has come for everyone to cross organisational and geographical boundaries and commit to working together in the best interests of autistic CYP and their families.

Our recommendations are based on seven principles and the evidence that underpins the recommendations is laid out within this report. The recommendations are pragmatic in nature and recognise that the UK will be in a perilous financial state in 2024, meaning that solutions must make best use of existing capacity and not simply involve cash injections (which we would argue are anyway insufficient). What is needed is a change in mindset, rather than changes to funding allocations per se. We note that the autism assessment and support crisis worsens each year despite decades of attempts to reverse the problems [20]. Thus, we argue that there is a need for the next UK government to act at pace.

These recommendations do not pretend there is a magic wand. Rather, they avoid the trap where the impossibility of perfection is a barrier to improvement (so nothing changes). They do provide a platform that would allow the UK to harness the scientific method to learn what works best for which community – noting that science is society's most powerful tool for improving health and wellbeing.

> "It's not just CAMHS. I'm talking health visitors, probably midwives, school nurses, social workers, across the board... we're assigned these workers who **do not understand what our children need and what we need."**
>
> - Parent of an autistic young person

Our seven principles

1

Putting our children first – The future of a country depends on a healthy workforce, equipped with the skills needed by the economy and society. Childhood determines long-term health and is *the* critically important period for developing the core skills needed to function within society [3]. Logic thus dictates that the UK must prioritise children if we want to enjoy a healthy future. A more proactive and timely approach to meeting the needs of autistic CYP will ensure that they are able to reach their potential, and reduce the longer-term demand for health, social care, and other services.

2

Addressing inequity – This will reduce the financial burden of poor population health on public services. Concurrently, *economic stagnation must be reversed* to generate wealth and ensure the UK makes the best use of all its assets (i.e., the brilliant young minds located across all our communities). The UK's structural inequity is laid bare within the autism assessment pathways and a failure to support this population will starve the UK of talented individuals within the future workforce.

3

Adopting place-based approaches – Geography, culture, economic activity, and other factors vary between localities, changing the way that support needs manifest, and the way communities prefer to engage with services. New approaches to reaching and helping families must be planned and aligned to the needs and preferences of the locality and its communities. There are many cultural factors that impact autism assessment, including stigma and reduced autism awareness, and these local contexts must be addressed for efficient service delivery.

4

Working together effectively across our public services – The needs of children and families cannot be neatly divided into silos such as "health", "education", "social care", "criminal justice" etc. We must recognise that our current organisational arrangements are not fit for purpose and find new ways of delivering connected public services so that the necessary holistic ("whole system") solutions to complex problems can be implemented. We recommend in this report how such connected service delivery can be operationalised from the perspective of autism.

5

Putting education at the heart of public service delivery – Schools and other educational settings need to be at the epicentre of support. For example, typical "outside support" from specialist services (e.g., child and adolescent mental health services (CAMHS)) needs to be delivered within the school gates. In doing so, we start to remove the additional barriers encountered by the most disadvantaged children, reduce the burden placed on families, and destigmatise autism support. A genuine attempt to improve autism healthcare delivery will involve closer working between health services and education settings.

6

Establishing Universities as the "Research and Development" departments for local public services – Universities can bring together insights from across multiple disciplines, ensure decisions are based on the best possible evidence, oversee evaluation of service delivery and train future health, social care, and education professionals. There is a wide scientific literature that captures international approaches to improved autism care and universities must draw on existing evidence, as well as researching specific inequalities, to support public service colleagues [21].

7

Using and sharing information across public service providers effectively – Data are currently collected within organisational silos, which fails to reflect the reality of how families interact with services. Only by connecting our public service data (i.e., education, healthcare, social care etc.), can we: (i) begin to understand how services intersect and interact within families; (ii) allow the essential information sharing that will safeguard children. The information held within education systems can help clinicians (and services such as social care) to make more accurate decisions, faster. Information held within health systems could help schools and other educational settings identify children with a greater likelihood of having autism and thereby decrease the time for children to enter the autism pathway.

> **"It just makes me so angry** that we're all going through the same thing. It's like we're rewriting it over and over again, aren't we, for each child and the amount of time that it's taken."
>
> - Parent of an autistic young person

The evidence

A failure to provide appropriate autism support results in poor long-term outcomes in social and individual functioning, high rates of associated health problems, and an increased prevalence of connected conditions (such as sleep difficulties and mental ill health) [22]. The recommendations within this report are based upon consideration of the following evidence and our seven principles previously outlined.

The UK government must prioritise support for autistic CYP

£1.5M to support an autistic person over their lifetime [12]

The evidence is clear: CYP with autism and common, co-occurring conditions such as ADHD, and/or anxiety, can thrive in mainstream education if their needs are adequately supported in a timely manner.

It is estimated that it currently costs £1.5 million to support an autistic person over their lifetime due to the complexity of their needs and the greater need for specialised help [16]. Autism and other commonly co-occurring neurodevelopmental disorders increase the risks of physical health morbidity and multimorbidity in later life [23]. Early identification and support can mitigate the negative effects on an individual's physical health and the associated costs.

The evidence is equally clear that CYP often do not receive the support they need for many years, exacerbating their needs and causing stress and frustration to the family (often creating associated mental health problems which generates yet further pressure on our systems) [24].

> "Professionals are becoming resentful of parents because **they think we're obsessed by getting a diagnosis** and it's not that at all, it's that we can't get [support] without it… so it's just this silly catch-22."
>
> - Parent of an autistic young person

A major barrier in our existing systems is the perceived need for a medical diagnosis of autism before any child can receive support. In many cases, there is no legal need for a diagnosis but the perception among schools and the wider community that this is a requirement prevents children from accessing support [25]. This relates to another problem within our current system around the "medicalisation" of developmental difference. This often means that a child needs (or is perceived to need) a medical diagnosis to access support, but the health system simply cannot meet the demand for all such assessments [5]. In turn, this can prevent timely access to the essential help a child needs in school. Autistic CYP who have newly immigrated to the UK also need a formal diagnosis in the UK before they can access service support, despite having a diagnosis in their home country; a simpler process is desperately needed. From an educational perspective, this lack of equitable provision can result in children "failing while waiting" because of system failures. As a society, we cannot afford the costs associated with young people leaving school without core skills (e.g., literacy which relates closely to health literacy and, in turn, long term health prospects in adulthood).

Some children who show developmental differences require specialist healthcare assessment and support – and, indeed, have a statutory right to access such healthcare. One major difficulty in debates around improved autism support is a tension between groups who understandably wish to avoid the perils of "medicalisation" and groups who wish to ensure that children obtain the healthcare support they need. While these groups may differ in their views on autism identity, all these groups are notably motivated by a common desire to support children, and debates are often the result of miscommunication on both sides. Thus, there is a need for precision in language, and rigorous frameworks that provide a structure for considering the pathways of developmental difference. Page 9 details two World Health Organization frameworks that provide a useful structure for approaching debates around support for autism and related developmental differences.

The evidence suggests we need to further promote, refine, and define a "needs-led" approach instead of relying on a "diagnosis-led" system [3]. Early identification is the norm in a "needs-led" approach and faster, effective support can be offered, without relying on a diagnosis. The sooner individual needs are identified, the sooner they can be supported, leading to better long-term outcomes (and reducing the long-term costs on public services). Future reports will highlight evidence-based suggestions for creating "needs-led" approaches across a range of issues.

> **"Giving support regardless,** even if they don't have a diagnosis of autism."
>
> - Autistic young person

> "Unless [you've] got a physical diagnosis, **schools won't support, which I completely disagree with,** because if you're on the waiting list or you're trying to get that diagnosis, you're going years without support."
>
> - Autistic young person

Inequity must be addressed in autism pathways

The UK is struggling with problems associated with inequity. Inequity can be illustrated vividly through a comparison between the North and South of England. Children in the North of England are more likely to live in poverty than their Southern peers – and increasingly so [26]. Poverty leads to worse physical and mental health outcomes, lower educational attainment, and lower lifelong economic productivity [26]. Poverty also maps onto healthcare inequity (i.e., access to the appropriate health systems) and this can be seen clearly via the prism of autism [3].

The evidence shows that children born to mothers without educational qualifications will receive an autism diagnosis two years later than their peers and are two times less likely to receive the diagnosis compared to children born to mothers with A-level qualifications or above [27, 27].

The issues around timely identification and support are exacerbated for girls, who are more likely to be misdiagnosed and diagnosed later than boys, or not at all [5]. These differences are likely to be due to diagnostic criteria, assessment tools, professional training, and general awareness of autism being based on male presentation and the ability of girls to mask their autistic traits.

Bradford has created a first-of-its-kind connected database that contains the primary- and secondary-care health records of citizens across the Bradford district that are linked with education records, social care, policing data, etc. [28]. The database is an incredibly powerful research tool that allows scientists, working with policymakers, to undertake holistic data science that can shine a light onto critical social issues that span disparate services.

Evidence from the Connected Bradford database showed that 77% of CYP diagnosed with autism were male, indicating large numbers of autistic girls in the district who had not been identified (given national norms) [5]. These quantitative insights were explored further through interviews with people who have lived experiences of the autism pathways.

Parents reported waiting over four years for an autism assessment for their daughters, which is in stark contrast to the recommended three months [29]. Although males also face long wait times, figures suggest that males were on average more likely to be diagnosed younger than females [3]. Therefore, many girls are being failed by not receiving a timely assessment and related support. This research demonstrates the power of connected datasets coupled with qualitative investigation in identifying and understanding problems.

The Bradford district provides a devastating illustration of the continuously increasing wait times for autism assessments. Bradford autism services have the capacity to conduct 90 assessments a month but receive over 200 referrals every month on average. In the 2022/23 academic year, there were 926 dual assessment referrals for autism and ADHD, which has increased by 575% since 2019/20. In June 2023, 2579 CYP were waiting to be seen by autism services (1285 waiting for an autism assessment and another 1294 waiting for an autism and ADHD assessment), with waiting times up to 110 weeks (over 2 years). After waiting for an assessment, most of these children will receive a diagnosis of autism (in Bradford the "conversion rate" is 86%). This highlights the importance of needs-led approaches, to prevent CYP going for years without the support they need.

> "Girls have been diagnosed later because of **failings in people's training and responsibility."**
>
> - Autistic young person

Moreover, these systems show structural inequalities as can be seen clearly in Figure 1, showing the percentage of CYP diagnosed in a particular demographic for autism or ADHD from newly analysed Connected Bradford data. For example, around 0.7% of Asian females were diagnosed with autism, around 1% of "Other" females, and around 2% of White females. White individuals are far more likely to have a diagnosis across the board for both autism (2.63x) and ADHD (5.32x) when compared to Asian individuals. Furthermore, males are, on average, far more likely to have a diagnosis than females (Autism: 2.70x, ADHD: 3.32x). While this research included males and females, it is worth noting that people of non-binary genders often face additional barriers to accessing autism pathways [30]. Autism pathways are reported as being the most difficult chronic health condition for transgender and non-binary people to navigate [31].

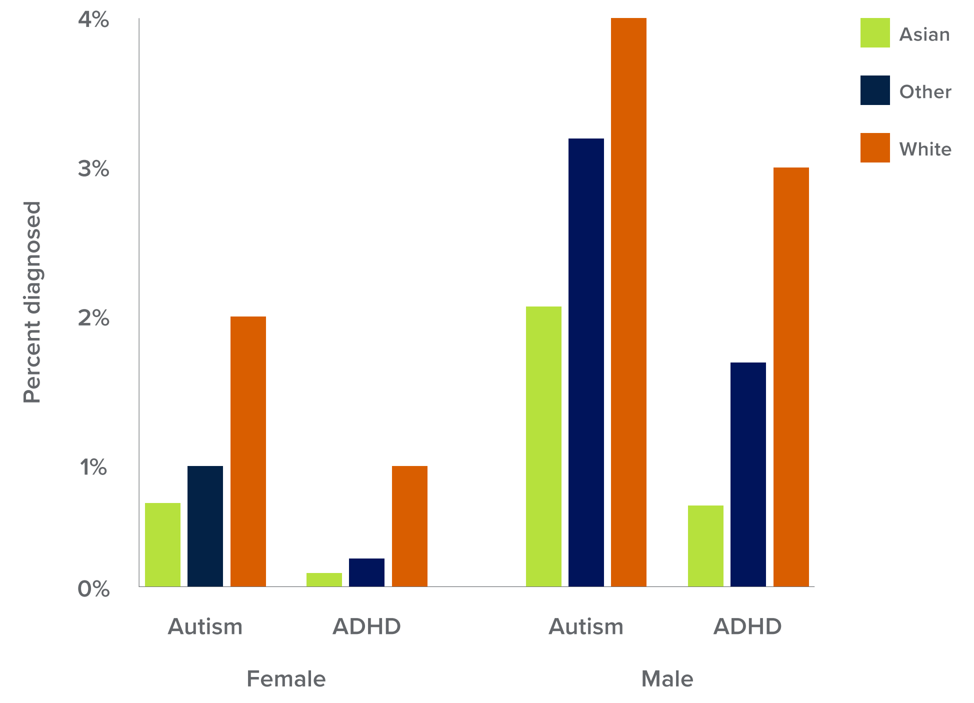


Figure 1: Percentage of individuals diagnosed with autism or ADHD by sex and ethnicity. Note that analyses use demographic data from the Department for Education school census. The category of ethnicity is therefore Asian, in alignment with census categories, but the sample is predominantly South Asian – and primarily Pakistani – in heritage.

Continued...

Qualitative work also highlighted several issues raised by autistic females [5]. Females consistently reported "masking" (a coping mechanism in which individuals minimise autistic characteristics to fit into the social environment) as a deliberate decision that became an unconscious activity with time and practice, although some girls may never be aware of their masking behaviours [5, 32]. CYP described the fear of negative social evaluation if they did not mask and said that disguising their social interaction difficulties resulted in internalised mental ill health symptoms (such as anxiety and depression) [33].

The ability to "mask" their difficulties hindered the recognition and support of the autistic girls, with education professionals dismissing parents' concerns if behaviours were not observed within the school environment. Furthermore, participants felt that schools did not recognise or support their needs until academic attainment was directly impacted by their difficulties [34].

The evidence suggests that improving awareness and education about sociodemographic differences in autism presentation could accelerate the process of identification and support [3]. However, the evidence also suggests that this would require a multifaceted approach, with a concerted effort across education and health services, with families involved in the planning process [17].

> "The person I was at school and the person I was automatically at home were **two completely different people.**"
>
> - Autistic young person

> "I was holding up to the standards they had... **it was never a concern to them** to look into maybe the weird things that I did do, because **the only thing they were looking at was if I could get the grades.**"
>
> - Autistic young person

Place-based approaches must be adopted when addressing the autism crisis

Evidence from across the UK shows that CYP from ethnic minority backgrounds experience lower rates of identification of autism and often experience more severe difficulties [35]. There is compelling evidence of underdiagnosis among bilingual CYP and ethnic minority CYP in comparison to White British CYP (see Figure 1) [36].

Clinician bias, discrepancies in diagnostic measures, reduced awareness, masking, cultural beliefs, biological reasons, and access to services across ethnic groups all contribute to ethnic inequalities [35]. The geographical concentration of ethnic groups can help explain why a place-based approach is so important when addressing structural inequity in autism assessment.

These issues are further compounded by intersecting factors such as gender and socioeconomic disadvantage [3]. The current fragmented system and lack of data linkage between health and education sectors also contribute to challenges in accessing timely support.

Analysis of the Connected Bradford dataset confirmed previous reports of ethnic inequalities in autism diagnosis and revealed similar patterns across the Bradford District [3]. These quantitative insights were explored further through interviewing people with lived experiences of the autism pathways. The evidence showed that stigma, lack of understanding, and cultural beliefs about autism were major barriers in acquiring a diagnosis and receiving support, with parents facing blame, privacy concerns, and a lack of awareness. Parents with autistic CYP report not raising concerns about their child's unmet needs to schools out of fear that their parenting would be judged [37]. Language barriers also posed challenges, especially for those less proficient in English [3].

The evidence from Bradford has emphasised the need for culturally competent practice; information on autism should be made available in community languages, and for interventions to be culturally sensitive. Evidence suggests that the most promising interventions for autistic children up to eight years old are naturalistic developmental behavioural interventions, these take place in natural settings and involve the child and professional taking equal roles when using behavioural strategies to learn skills [38, 39].

Many of those interviewed suggested that raising awareness of autism and the support that is available in South Asian (and other ethnic minority) communities was key, as well as ensuring any intervention or support is culturally sensitive [3]. In addition, it is vital that the pathways to receiving support are made much easier to navigate. As well as pathways differing across regions, services are continuously changing criteria to access support, adding to the complexities of navigating the pathway. By connecting services (i.e., schools, healthcare, and specialist services) and working as one, children and families can be better supported and, ultimately, autistic CYP will be able to thrive.

> "If you're raising concerns about your child, it's gonna be **easier to speak to someone in your own language to do that, isn't it?"**
>
> - Parent of an autistic young person

> "Kids that are higher functioning from a South Asian background are then even **more disadvantaged."**
>
> - Focus group participant

Universities must become the "Research and Development" departments for local public services

Through community engagement, universities (in partnership with hyperlocal charities, schools and other institutions) can play a key role in ensuring that research is relevant and useful. The Lancet Commission brought together leading clinicians and other healthcare professionals, researchers, and autism community representatives (autistic people, their parents, carers, teachers, and allied professionals) from six continents to identify strategies to improve the future of care and clinical research in autism [40]. The Commission called for coordination and collaboration between healthcare, education, finance, and social sectors across the lifespan, and the active inclusion and participation of autistic people and their families in the decisions made about them. This responds to an increasing demand from autistic people for opportunities to be involved in the research- and practice-based decisions that impact on their lives, as exemplified by "nothing about us without us".

There is under-investment in autism research in the UK compared to the US and Australia. In addition, autism research efforts do not always reflect the views and priorities of the autistic community or involve the community in shaping the research agenda, its implementation, and the dissemination of its findings [41, 42]. We need more inclusive research involving partnership and collaboration with community members; citizen science where researchers partner with community-led projects (e.g., looking at what can be developed and changed in schools to mitigate the challenges autistic students may experience, such as anxiety around transitions, or problems with social interaction [43]).

Participatory approaches can contribute to practical knowledge by valuing the perspectives of the autistic community on the strengths, skills, needs, and support priorities of autistic CYP, to optimise learning and wellbeing [44]. Participatory approaches challenge the "traditional, unidirectional research pipeline from basic science to intervention development" which is evident in much of the autism research, or the use of measures and interventions that do not always make sense to autistic people, or are inconsistent with their views and experiences [45, 46].

Collaboration between community and academic partners can build capacity for effective services and improving clinical outcomes [45]. These collaborations can build local capacity and contribute to the development of culturally and contextually appropriate interventions that address locally perceived needs [47].

University education departments can also play an important role in supporting schools to become more autism-friendly. Australia is far ahead of the UK in this respect with the world's first national, cooperative research effort focused on autism under the Australian Government's Cooperative Research Centres (CRC) [48].

Autism CRC provides independent, national capacity to develop and deliver evidence-based outcomes through a unique collaboration with the autistic community, research organisations, education and health professionals, industry, and government. A similar collaborative partnership between universities, schools, other educational settings, and health professionals would be greatly beneficial within the UK.

> "I think the **training would be really helpful** if it was put together [by] **people with lived experience.**"
>
> - Parent of an autistic young person

Supporting schools, parents, and carers and professional development for teachers

Researchers argue that planning and resourcing for diverse needs should be "baked into our school systems, rather than overlaid as optional extras" [15]. This requires schools to be shaped by a neurodiversity affirmative model, to inform thinking about classroom adjustments that could be made to support autistic CYP.

Creating a visually accessible environment by reducing "visual clutter" and providing materials against a plain or dark background to minimise visual effort and maximise visual attention - including teacher clothing and wall/floor coverings.

Delivering low arousal teaching, with short, clear instructions delivered in a calm and even tone. Multiple methods of communication should be used by staff, including both written and verbal communication.

Relaxing school uniform policies – this supports pupils with sensory issues who cannot tolerate wearing the uniform.

Maintaining a consistently structured school day, and structured and calm transitions and lunch times.

Removing the sounding of a bell between classes, which generates a calmer atmosphere for all.

Providing absolute clarity of expectations for all students and staff, regularly communicated.

On page 35, autistic young people share their 12 top tips for supporting the autistic community.

These adjustments would likely also help both other neurodivergent and neurotypical pupils.

There is also a need for improved teacher education – both initial teacher education and ongoing professional development, to enhance understanding of autism and support schools to consider, implement, and evaluate changes to the learning environment.

In Australia and the US, there are online resources to support teacher awareness (e.g., inclusionED which is an online professional learning community, co-designed with educators, for educators). It provides evidence-based teaching practices and tools to support diverse learners in inclusive classrooms. https://www.inclusioned.edu.au/

Additionally, the Autism Education Trust developed an extensive collection of resources which have been co-produced with the autistic community. https://www.autismeducationtrust.org.uk/resources

Health and education must work together for autistic CYP

Research suggests that autistic CYP are at an increased risk of being excluded from school. Using data from the Connected Bradford database, analyses found that children who had been referred, but were still awaiting an assessment, were at greatest risk of being excluded from secondary school [4]. Autistic CYP who had a diagnosis were less likely to be excluded from school, compared to those awaiting an assessment, suggesting a diagnosis, and subsequent support, has a protective effect [4]. With waiting times increasing nationally, this represents a growing risk to education outcomes, as well as individual and societal costs. The evidence suggests that many autistic CYP end up in Alternative Provision (AP) with much higher associated costs than education [49].

School exclusion has profound negative implications, affecting children's academic performance and overall well-being [50]. According to studies, only 7% of permanently excluded or frequently suspended students pass crucial exams, demonstrating the negative impact of exclusions and insufficient AP [4]. The parents of autistic CYP are often unable to engage in the economic workforce because of their child's exclusion. Exclusion also has long-term effects on a child's psychological well-being, contributing to higher risks of crime involvement, anti-social behaviour, social isolation, and limited social capital [49]. Schools are often unable to explore drivers of behaviour and instead rely on a clinical diagnosis and other services for assistance.

These findings demonstrate the issues around "diagnostic-led" systems, whereby children identified as having difficulties and referred for further assessment but still waiting for that clinical diagnosis do not receive the necessary support. This lack of support causes a myriad of difficulties within the classroom and means existing problems escalate.

Notably, the evidence shows that once appropriate support is in place (following diagnosis), autistic CYP are less likely to be excluded [49]. These findings emphasise the need for an integrated approach to the implementation of autism across health and education settings.

ONLY 7% of permanently excluded or frequently suspended students pass crucial exams, demonstrating the negative impact of exclusions and insufficient Alternative Provision [4].

> **"It's a broken system that we need to reset because it's identifying and supporting need,** no matter what that is, without that necessity for EHCP or a diagnosis."
>
> - Focus group participant

Schools, nurseries and other educational settings must be at the heart of autism service delivery

The evidence is clear: the divide between health and education service delivery means that autistic CYP frequently fall in the gaps between schools and health services. Thus, many CYP experience health barriers to education that could and should be supported, but their needs are not being met due to siloed working.

An example of a national programme linking health and education is the Special School Eye Care Service, launched in 2021 [51]. Fewer than 7% of CYP with special educational needs have had an eye check, yet those with special educational needs are 28 times more likely to have a vision problem. Providing in-school assessments has allowed children requiring help to access vision support more effectively. Special School Eye Care Services allow strategies that improve visual learning to be given directly from health to education professionals in real time [52].

The long-term consequences of not supporting autism are devastating, with evidence showing that such health needs increase the risk of CYP being absent from school and ultimately becoming NEET (Not in Education, Employment or Training) [53]. Moreover, the evidence shows that improving the educational attainment of CYP decreases the risk of long-term physical and mental health problems.

There is accumulating evidence that health and education can work together effectively to ensure that CYP's health, education and social needs are met in a timely fashion [3]. Autistic CYP frequently possess a plethora of strengths, such as attention to detail, and have the potential to thrive in education if appropriately supported. The SEND crisis and the waiting list problems associated with autism (and other developmental differences) is just one example of the need for health settings to work in partnership with educational settings to effectively tackle problems that affect both services.

The evidence suggests that multidisciplinary clinical teams can work effectively in school settings, and this opens the possibility of new ways of working (especially in our most disadvantaged communities). In the next section ("innovative approaches trialled in real world settings"), we highlight an innovative approach (SUCCESS) where autism assessments were conducted in partnership with schools [54].

Integrated care systems provide an outstanding opportunity for such integration, but schools and nurseries must be properly represented within these groups.

> "CAMHS said to me, **'we're in crisis. We're letting children down.** Please, can you write to your MP' And I was like, if I had time, I would do that."
>
> - Parent of an autistic young person

Fewer than 7% of CYP with special educational needs have had an eye check, yet those with special educational needs are **28 times more likely to have a vision problem.**

Information must be shared across health and education when identifying autistic CYP

The evidence is clear: the inability of public service organisations to share information acts as a major barrier to planning and delivering integrated care [3].

Public services are organised and delivered within specialist organisations (e.g., education, health, social care, and policing). Policies are developed within political structures that map to these organisations both centrally (e.g., Department for Education, Department for Health and Social Care, Ministry of Justice, etc.) and at a local level (e.g., multi-academy trusts, hospital trusts, local authorities, and regional policing authorities).

As already discussed, the fundamental problem with this structure is that the lives of families and individuals do not fall neatly within these organisational silos. This underpins the drive to move towards "integrated care systems" where organisations are better connected. Unfortunately, the planning of integrated care is prevented through a lack of knowledge about how services intersect and interact within the lives of families. The delivery of integrated care is hindered because practitioners cannot share information across organisations.

For example, health services are often aware of children with rare chromosomal conditions known as "neurodevelopmental copy number variants" (ND-CNVs). ND-CNVs are minor genetic rearrangements where a small segment of a chromosome is missing or duplicated. Cardiff University research has found that a range of ND-CNVs have been robustly associated with autism [55].

It has been found that 1.99% of children in the Born in Bradford cohort have at least one of these ND-CNVs, highlighting that, although each of these conditions is individually rare, they are collectively common within the population [56, 57]. Upon examination of the Early Years Foundation Stage Profile scores, children with ND-CNVs exhibited early indications of language and communication challenges, as well as physical development concerns and autistic traits in comparison to their peers [57]. Given the significant impact ND-CNVs can have on many functional domains, children with these conditions often require specialist care. Yet, recent research into the school experiences of this group reports the "fight" parents have with public services to secure SEND support for their child. Almost a quarter (23.1%) of parents of children with a ND-CNV are dissatisfied with their educational support [58].

The challenges experienced by parents of children with a ND-CNV when trying to access support are reflective of the SEND review findings – with parents struggling to navigate a complex, underfunded, and structurally unequal system, which is more accessible to individuals of higher socioeconomic status and riddled with processing delays [59]. Under these difficult circumstances, parents of CYP with a rare chromosomal condition face additional challenges in proving need due to limited awareness of these conditions. In some cases, parents seek additional and more known neurodevelopmental diagnoses (such as autism) to secure support, even when the needs of their CYP are already apparent, contributing to even longer waiting lists for autism diagnostic services and inefficient use of resources.

The number of children diagnosed with a ND-CNV early in life is increasing as diagnostic technologies improve, and this can be expected to continue considering the ambitions of the UK regarding the future of genomic medicine [60]. The opportunity for early intervention for children diagnosed with a ND-CNV is great but will require information sharing across health and education if we are to provide comprehensive support to these children.

The evidence shows that it is possible to integrate information across health and education and understand the intersections and interactions between services to ensure early school support is in place for vulnerable children, such as those with a ND-CNV. Bradford has proved the principle with Connected Bradford and provided a methodology that should be scaled up across the UK to inform a national approach [28].

HOW GOVERNMENT CAN HELP HEALTH AND EDUCATION SYSTEMS SHARE INFORMATION TO CREATE THE BEST OUTCOMES FOR CYP

Education systems record children's Unique Pupil Number (UPN), while health systems record NHS numbers. The lack of a common denominator currently hinders data linkage. To facilitate cross-sector data sharing, the UK government must take the following action:

Use an individual's NHS number as a single unique identifier across public service records.

This government action will enable information sharing and allow our public sector organisations to work together more effectively to meet the needs of the autistic population.

> **"You absolutely have to have a governance...** governance in place so that health, education, social care do work together and are prepared to share their budgets and be flexible in their approach."
>
> - Focus group participant

Innovative approaches trialled in the real world

The recommendations made within this report are based on innovative ways of working that have been trialled in real-world settings.

We highlight five evidence-based approaches – new tools and ways of working – designed in alignment to the principles set out in this report. We also highlight the incredible work undertaken in Limpsfield Grange school which shows there are solutions to the challenges. These approaches demonstrate the capacity of our schools, universities, and health institutes to innovate through applied research. They represent and show what can be achieved by combining academic expertise with the skills and knowledge of front-line professionals and the insights of children and families with lived experience.

These approaches show that it is possible to take different approaches to the identification and support of autism that do not follow the traditional models of service delivery. We show that education data can identify autistic CYP falling "under the radar" (underpinning our first recommendation around information sharing). We show that autism assessments can be conducted successfully in schools (hence our second recommendation for "whole system" partnership working). We highlight how these innovations have been developed in other areas (supporting our recommendation for place-based working). We showcase an oral health intervention that illustrates the usefulness of providing training around the needs of the autistic population (our third recommendation). Finally, we draw attention to the availability of psychoeducation tools.

1

Using education data to identify autistic CYP

> **“If it was easier [to access help],** I think more people would pick up on the signs a bit earlier.”
>
> - Focus group participant

The Early Years Foundation Stage Profile (EYFSP) is a universal teacher-reported assessment completed for all children in Reception classes across England.

Evidence suggests that the EYFSP could act as a “red flag” for identifying unmet needs within the population [61]. This could then trigger a process of assessment and support provision. Such practice could be particularly useful in addressing structural inequalities (i.e., identifying the CYP who are more likely to slip under the radar because of ethnicity, gender, or socioeconomic inequalities). This highlights the need for tailored support-led tools which can identify children with difficulties in communication and social skills throughout their time at school.

The evidence also shows that the education system has information that could be useful to clinicians when assessing a child for autism [7]. Autism assessments are lengthy processes typically conducted in environments unfamiliar to the child (i.e., clinics). The ability to efficiently share information on how a child behaves in the classroom could speed up the autism assessment process and help reduce waiting list times.

In many geographical areas, CYP sit on a waiting list for several years before being assessed for autism. The inherent difficulties in navigating the autism pathways mean that most children on the waiting list will be diagnosed with autism (e.g., in Bradford the “conversion rate” is 86%) [17]. This observation suggests that it would be reasonable to assume an autism diagnosis and provide support to all children currently on the waiting list in many locations. It further suggests that examining the EYFSP for children on the waiting list could provide a rapid indication of the likelihood of a child being autistic with good sensitivity and specificity. We recommend that such approaches are explored to address the unacceptable waiting times that currently plague the system and fail to serve CYP and their families.

The EYFSP covers a range of academic (e.g., mathematics and literacy) and non-academic (e.g., socioemotional development, language) elements. Teachers report on many of the behaviours that form the basis of standardised clinical autism assessments, raising the prospect that the EYFSP could flag unidentified autistic CYP, with a low score indicating that the expected progress in a domain has not been met. This hypothesis was tested using data from the Born in Bradford longitudinal birth cohort study through the ‘Digitally Acting Together As One’ (DATA1) project.

The evidence showed that children with low total scores on the EYFSP were over 25 times more likely to receive a diagnosis of autism [61]. Similarly, children who failed to reach a good level of development were 4.8 times more likely to have an autism diagnosis than those who did; similar findings have also replicated in a larger population-based cohort (the Connected Bradford database) [5].

The research further mapped some EYFSP elements onto four aspects of autism (social skills; language and communication; imagination; and repetitive behaviour) to create an “autism-specific weighted sub-score” [61]. Analyses revealed that children who scored poorly on the autism-specific score were approximately 50 times more likely to receive a confirmed autism diagnosis, compared to children who did not receive a low score [61].

These results show that teachers are well-positioned to identify developmental differences. This is intuitive, as teachers can often draw on years of experience about the behaviours expected of a child at a given age. In contrast to a snap-shot assessment by a health professional, teachers observe children throughout the year, enabling a fuller picture of the child’s global functioning, and facilitating the identification of the children who show different behaviours. We acknowledge the growing pressure placed on teaching staff to take on additional responsibilities on top of their already overstretched workload. Therefore, our recommendations focus on reasonable adjustments that can be easily implemented within the classroom as part of inclusive high quality teaching.

2

Autism assessments in schools

> “Even if we ignore diagnosis and focus on the needs… **the relationship between the school and the parents** is so important.”
>
> - Focus group participant

The SUCCESS (Supporting Understanding of Children’s Communication, Emotional and Social Skills) project was trialled in 10 Bradford primary schools through the Department for Education’s Opportunity Area programme [13].

SUCCESS involved the deployment of multi-disciplinary teams **within the school gates** to conduct autism assessments for children identified as being at risk of undiagnosed autism (and other neurodevelopmental disorders) [54]. The evidence showed that clinicians were able to combine their clinical observations with those of teachers, who observe the child working, learning, and playing in a familiar environment every day. Many of the additional barriers that families often face, such as hesitancy about mental health services due to cultural beliefs, were overcome due to the trust families placed in the school. The SUCCESS approach allowed more children to access autism services and thereby reduce the likelihood of missed appointments and the resultant costs [54]. The evidence from the SUCCESS trial suggests this approach could provide major long-term savings and reduce waiting times for autism assessment and support [54].

> “…to be able to participate in that piece of work was fabulous… [it’s] **enabled us to facilitate work between services** that would normally only be available post-diagnosis.”
>
> - Educational psychologist

3

Tailoring promising approaches to place

> **“We’re not having a universal offer.** It’s a bit of a postcode lottery really.”
>
> - Parent of an autistic young person

Innovative approaches should not be “dragged and dropped” from one locality to another. Instead, they should come with guidance and methodologies to help local leaders create something tailored with and for their communities.

DATA1 and SUCCESS were implemented in Bradford and found to be useful approaches. However, these approaches need to be tailored to the needs and priorities of an area, given the differences in autism pathways and cultural milieu across different regions.

In line with this “place-based” principle, DATA1 and SUCCESS have been trialled successfully in different areas across England (Cambridgeshire, East Sussex, Barnsley, and Manchester) using a “test and learn” methodology through the Department for Education’s Opportunity Area initiative [61].

In Cambridgeshire, for example, the approach was adopted to focus mainly on girls in Years 5 and 6 (9-11 year olds), who, according to previous research, were less likely to be identified due to the masking of their difficulties in the classroom [34]. It was also noticed locally that autistic girls showed behaviours that were missed by traditional methods of diagnosis, (e.g., the Autism Diagnostic Observation Schedule; ADOS) [5, 37], with additional investigation often needed to uncover behavioural issues.

The team in Cambridgeshire further found that specialist teachers could observe girls skilfully masking their autism behaviours, but this required experience. The evidence suggested that subtle behavioural markers (e.g., discrete stimming in the form of small finger movements) would go unnoticed in a busy classroom if teachers were not trained to recognise these characteristics.

The Cambridgeshire project highlighted the need for more specialist training around the presentation of autism across different demographic groups [37]. The project also showed the value of listening to voices from different disciplines and viewpoints (including pupils, families, schools, health, and specialist teachers). This multifaceted approach enabled rich discussions on the appropriate support for a child, support that was based on true triangulation of need.

In East Sussex, the **Early Identification of Autism and Teacher Training in Primary School Settings Project** provided autism training to teachers, teaching assistants and SENCOs to promote identification and needs-led support for potentially autistic pupils. Teachers and parents were actively involved in the screening process for autism and the diagnosis process was conducted in schools by assessors with relevant training and background on autism. Clinicians supervised the diagnostic process via video recordings. This was proved to be a successful pathway to autism diagnosis and early identification of the pupils needs, significantly reducing clinician’s time spent on each diagnosis.

In Mansfield and Ashfield, the **Young Wellbeing Hub: Early Identification Project** implemented SUCCESS [62]. They found that by outsourcing caseloads to a “Young Wellbeing Hub”, it was possible to provide more efficient support than available through overstretched services (such as CAMHS). The evidence showed a reduction in waiting times, waiting lists, and patient numbers – meaning more CYP received the support they needed to thrive.

In Nottinghamshire, the **Early Identification of Autism** project aimed to identify communication and interaction needs in 7–11-year-olds to reduce assessment waiting lists and promote early intervention. The project brought together health and education colleagues to undertake assessments so that timely, appropriate support could be identified and delivered to CYP, families, and schools at a much earlier stage in a child’s educational journey. The evidence showed that training allowed school staff to gain a unique insight into the diagnostic process and improve knowledge about autism. In turn, this led to children’s needs being identified and tailored support offered at an earlier stage.

> **“I think schools need a lot more training on autism in girls.** I think when you get autism training, it’s mainly looking at kind of how boys portray it and girls can be completely different to that.”
>
> - Autistic young person

4

Oral health approaches for autistic CYP

> “I just feel for some of these parents that probably don’t know how to find this information and **they’re struggling.”**
>
> - Parent of an autistic young person

The toothPASTE project works with autistic children, their families, and healthcare professionals to co-design an oral health support package. toothPASTE aims to help prevent tooth decay, a significant public health concern [63]. Around one in four five-year-olds in England have tooth decay and is the primary reason for hospital admissions, incurring over £50 million annually in NHS costs [64, 65] Tooth decay leads to a domino effect of significant consequences, such as pain, problems with speech, sleep disruption, altered eating habits, and financial impact on families (including time off work) [66]. The evidence is clear: poor oral health has a direct impact on school attendance, potentially widening educational inequalities [67].

Tooth decay is largely preventable, however, twice-daily brushing with fluoride toothpaste and reducing sugary foods and drinks, can be challenging. Communication and sensory differences and rigid behaviour patterns can make oral health routines more complex for autistic children [68]. For example, toothpaste can be felt as an “explosion in the mouth” [69]. Research demonstrates that autistic children are less likely to visit the dentist [70]. When attending, they’re less likely to receive preventative treatments. This disparity is alarming, particularly as autistic CYP are twice as likely to need their dental treatment provided under a general anaesthetic – with each operation costing the NHS around £1,000 per child.

Parents of autistic CYP commonly report feelings of isolation and confusion, frequently describing tooth brushing as a “battle” [69]. The advice that parents receive around oral health is often generic and does not address specific autism challenges. This leaves these parents to seek guidance from professionals they encounter across early-year health, education, and the third sectors. Yet, evidence indicates that these professionals have limited training in oral health and are often unsure about what advice they should offer [71].

The experiences of parents and children within dental environments identify a crucial, yet often overlooked need – the necessity for “autism-friendly” places and mandatory training for health and educational professionals, aligned to an NHS clinical standard [72]. Parents reported feeling judged or dismissed by their dentist. Moreover, research shows sensory challenges are not only limited to inside the mouth, they also include the harsh glare of bright lights, the loud sounds of drills and electric toothbrushes, and overpowering smells in the bathroom and clinic [73]. This not only highlights the necessity for training professionals but also the importance of empowering and supporting parents in their homes. In response to these challenges, the toothPASTE project has worked with autistic CYP, their families, and early years professionals to develop a detailed prototype that aligns with their preferences and needs. The toothPASTE research identified what oral health support families need (including a website and resources) and a training package for early years professionals [69]. The training package, ready for September 2024, will allow early years professionals to feel confident that the oral health support they provide is correct and sensitive to the family’s needs.

The toothPASTE support package will aim to break the cycle of siloed working. This involves making the programme freely accessible to families (without the need for a formal diagnosis), while the training package will be simultaneously available across early years professionals, not just within healthcare. This whole-system implementation plan will be continuously refined in collaboration with local authorities and key stakeholders in West Yorkshire to ensure local relevance and effectiveness. This will learn from, and collaborate with, other programmes such as Healthier Together and Autism Central [74, 75].

5

Psychoeducation for autistic CYP

Researchers from the University of Sheffield have collaborated with the University of Derby, NIHR's Children and Young People Medtech Cooperative (CYPTECH) and Sheffield Hallam University's Lab4Living to co-design psychoeducational resources that help primary-aged children with autism or ADHD. Psychoeducational resources are those that teach an individual about their condition by providing support, information, and management skills [76]. Whilst psychoeducation interventions are recognised as being beneficial for these groups [77, 78] and recommended by UK clinical guidelines, there is little age-appropriate material currently available for CYP attending mainstream schools.

The resources developed within this project include workbooks for the CYP to complete themselves and help lay the foundations for the development of self-advocacy. Providing accessible self-advocacy training for CYP with autism and ADHD is fundamental for individuals' success in the long term [78] but particularly important for girls [79] due to the additional barriers they often face within educational settings [80, 81]. CYP, their families, clinicians, educational professionals, charities, and academics, have been central to the project throughout all stages of developing these resources; from identifying unmet need, to co-designing the content of the resource, to testing and developing initial prototypes. The resources have now been adopted by several schools and NHS Trusts and Councils across the UK [82].

> "The training needs to be wider, not just the teachers. **I'm talking about the caretaker. I'm talking about the lunchtime supervisors...** everybody should have all that same understanding."
>
> - Parent of an autistic young person

> "I think there's something about that **accessibility of information...** it's that real self-help element."
>
> - Focus group participant

What "good" looks like in autism education

Limpsfield Grange, in Surrey, is the UK's only special school solely for autistic girls aged 11-16 years. Their work shows that there are solutions to the challenges CYP face, that need to be adapted into neurodiversity affirmative mainstream school environments. Many of the students have additional needs including ADHD; speech, language, and communication needs; medical needs; and emotional difficulties associated with their autism. All the students have an Education, Health and Care Plan (EHCP) that outlines their needs. Many Limpsfield Grange students have had an incomplete experience of primary school, often with very poor attendance due to their previously undiagnosed autism, which led to persistent levels of anxiety that affected their wellbeing.

Limpsfield Grange offers a broad and balanced, challenging, and relevant curriculum, delivered by experienced and dedicated staff. Staff build relationships with students based on a deep understanding of their needs, and these relationships are key in supporting students to fulfil their potential. The aim of the school is to fully prepare autistic girls for successful lives in wider society, so that they can work and make their contribution to the world.

Limpsfield Grange believe that their students should be just as successful in their wellbeing, communication, and independence, as they are academically. This gives them the greatest possible chance of success as learners and in the wider world. This unique school teaches these skills as a unique subject area known as WACI (Wellbeing; Academic Achievement; Communication; and Independence). WACI underpins the curriculum and is credited as the reason Limpsfield Grange students are successful.

Wellbeing - promoting the importance of self-awareness and self-care that enhances both physical, and mental wellbeing so that each student develops the resilience to cope with the ups and downs of everyday life. Students develop their understanding of healthy and unhealthy relationships so that they are able to recognise any red flags and understand how to respond in a range of situations, with friends, family, online and in the wider community. They learn a range of tools for living safely online and develop the ability to recognise and manage the risks they may encounter online and offline.

Achievement - developing skills and knowledge, validated through externally recognised qualifications such as GCSEs, BTECs and Functional Skills that enable each student to successfully transition to their next education placement.

Communication - good communication skills are important for enabling our students to understand and be understood by others. We teach students how to interact with their peers and with both familiar and unfamiliar adults. Students develop social communication and interaction skills so they can engage confidently and meaningfully in a range of scenarios.

Independence - developing independence skills enables our students to manage their own lives and make their own decisions. Most functional life-skills can be learnt at home, so our focus is on developing skills for the workplace, managing money and understanding how to be a responsible and active citizen.

The holistic approach to educating the whole person within Limpsfield Grange leads to great outcomes for their students who make excellent progress in their academic studies, with **100% of students each year successfully transitioning to and sustaining a post-16 placement.**

Limpsfield Grange alumni attend universities across the country; have jobs and apprenticeships; they pay taxes; have friends; and lead **rewarding and fulfilling lives.** Limpsfield Grange aims for all autistic girls to have the support and opportunities offered to them to enable them to thrive.

Limpsfield Grange experiences

Some of the wonderful students at Limpsfield Grange reflect on their experiences.

This is what Connie, Sally, Darya, D'Arcy, Elizabeth, Rose, Baylei, Beth, Ellie, and Georgia had to say about life before Limpsfield:

> When I was in primary school, I couldn't keep up with the work and was made fun of – people called me "dumb" and "stupid". People always left me out of things including games at breaktime. I felt like an outsider and got cross. It's not nice to be in that position.

> I don't remember a lot from primary school, but I struggled with being with other people and got left out a lot of the time. With learning, I was put in a group with three boys away from the classroom. I didn't like that.

> I wasn't allowed to sit my SATs at primary school. I felt left out. I wasn't allowed to do them because I was dyslexic.

> I always felt in primary school that people never got me. I had one TA who was really nice to me. In maths I was only taught the basic things so I was never able to catch up with everyone.

> My experience of getting diagnosed was a rollercoaster. I was diagnosed with ADHD before autism, my autism diagnosis was a bit of a shock.

> My diagnosis took a while. The doctors thought I was hard of hearing then I was diagnosed with autism at around 8 years old. ADHD diagnosis was really weird – I didn't want to sit through the assessment and I remember them chasing me round and round trying to do the assessment. It was really stressful.

> My parents told my primary school about my diagnosis and the primary school kicked me out because they didn't believe me.

> They need to realise that girls can have autism too. It's not fair that they only diagnose boys. There needs to be more ways to help, not just CAMHS, but doctors should have an autistic department as well.

> They said I shouldn't have emotions. If I'm stressed out, I should be allowed to feel that way but staff at primary school didn't understand and would just say "stop it".

This is what Connie, Sally, Darya, D'Arcy, Elizabeth, Rose, Baylei, Beth, Ellie, and Georgia had to say about how health and education systems should change:

> People should all get what they need to be successful, not just autistic people. Everyone should have the tools to be a success.

> They need to stop separating neurotypicals and autistic people. There should be a fair and understanding system. People never understand us. It's really selective and there should be something different done. If they need help someone should be there to help them. People who can't get a diagnosis and haven't got a special school place should be offered help in the classroom rather than be taken out.

> Try not to have as much discrimination. I was called so many names in primary school because I was different.

> Sometimes schools can have stereotypical views. They just think it's a characteristic, not that it's a symptom of having autism.

> Teachers and TAs in all schools should get a better understanding of autism.

> We should be taught about autism, neurodiversity, and mental illness. This could help students more because lots of teachers don't understand their students' needs.

> Autism is different in everyone so they should know that, and also that you can have more conditions than just autism.

And here are their 12 top tips for supporting autistic CYP:

1. Movement breaks could really make a difference to autistic CYP in mainstream schools.
2. Primary schools could add an area where people can have a break if they're feeling stressed.
3. A changes board (where changes in routine are recorded) can really help so changes aren't a surprise.
4. Schools could have swings to help if someone is feeling really stressed.
5. Make teaching more specific – things are better when everything is clear and easy to understand.
6. Regular check-ins with a teacher or staff member are important for autistic people. Everyone should be offered check-ins if they need them.
7. Offer a counsellor to help people talk about their experiences. It would help with diagnoses.
8. More explanations on social rules that must be obeyed, to help autistic people to understand. People shouldn't get in trouble for reacting in a non-neurotypical way.
9. It's important for students in mainstream to be taught that autistic people might not understand things that they find straightforward.
10. Provide allowances for sensory needs (e.g., allow "fidgets" or students to undertake activities like crochet and doodling).
11. Schools should allow autistic CYP the option to choose their own timetable or provide more flexibility about the timetable.
12. If a student is feeling stressed, they should be able to ask for help and know that someone will speak to them.

Implementation

NHSE have provided two important and useful documents that could and should guide the implementation of the recommendations made within this report:

National framework to deliver improved outcomes in all-age autism assessment pathways

Operational Guidance to deliver improved outcomes in all-age autism assessment pathways

The “Framework” and “Operational Guidance” documents were co-produced with a wide range of stakeholders including people with lived experience (autistic people, their families, and carers). The documents identify barriers to the autism assessment pathway and provide evidence of good practice.

The societal challenge is twofold. First, we must determine how these guidelines can move from abstract (and easily ignored) aspirations to concrete and measurable actions across the UK. Second, we need to transform our systems so that the responsibility for implementing autism support does not lie solely with the health system.

The first challenge can be operationalised via existing NHS structures and frameworks. The 2022 Integrated Care Boards (Establishment) Order legally established 42 Integrated Care Systems (ICS) across England, with each ICS comprising an Integrated Care Board (ICB), an Integrated Care Partnership, local authorities, place-based partnerships, and provider collaboratives. ICBs provide a useful organisational structure through which autism services can be transformed [83].

> **“I wish that there were just more services available for them… **in all honesty, **there’s hardly anything…** our kids are the ones that struggle the most, but they get the least services offered to them.”
>
> - Parent of an autistic young person

We recommend that ICBs work together to create a single regional “point of truth” where families, expectant families, practitioners, and educational providers can obtain evidence-based health advice on autism. The advice can be hosted on NHS webpages and capture core principles whilst ensuring the messages are tailored for the region. The Healthier Together programme shows the effectiveness of such an approach [74].

Likewise, an existing NHSE framework for addressing health inequalities can be utilised to create change at pace. **Core20PLUS5** advocates a system level approach to inequity that targets the most deprived 20% of the national population (‘Core20’) [18]. Core20PLUS5 encourages use of the national Index of Multiple Deprivation (IMD) to identify where efforts must be concentrated. The IMD is the official measure of relative deprivation in England (with similar measures available across the devolved nations). IMD2019 combines and weights 39 factors across seven domains of deprivation (income; employment; education; health; crime; housing and services; living environment) [84]. IMD2019 allows geographical “hotspots” of deprivation to be identified and serves as a useful geographical guide to target health interventions.

Thus, Core20PLUS5 identifies where actions should be prioritised within an ICB area. Importantly, it recognises that the system cannot simply throw a switch and transition to new ways of working in every area across the UK. Pragmatically, we recommend that around three of the most disadvantaged wards are selected within each local authority area and new approaches to supporting autistic CYP are developed in each of these wards. We recommend working at a ward-level to reflect the existence of a democratic elected councillor who can provide local political support for the work.

The implementation of innovative approaches to the transformation of autism pathways within a small number of wards will allow an area to “test and learn” what works best and scale up a system level transformation in a manageable fashion.

> “I think services need to try and engage with the children as well, rather than just **completely ignoring them and going to the parents.”**
>
> - Autistic young person

Core20PLUS5 suggests that specific populations should be prioritised at a local level (the “PLUS” part of its name) [18]. Examples include ethnic minority communities, people with a learning disability, and autistic people. **We strongly advocate an approach where ICBs prioritise improvement of their autism pathways.**

We note that the evidence presented in this report also applies to other developmental differences (e.g., ADHD). Importantly, a sustained focus on one condition (autism) would allow the issues associated with system transformation to be trialled in a manageable fashion. This approach will yield the wider changes required in a shorter time frame than an approach that tries to achieve everything at once.

To ensure that addressing the autism support and assessment crisis remains a priority, we recommend that “Futures Groups” be established to support ICBs. Humber and North Yorkshire ICB have established such a group, and the Futures Group provides advice on how the ICB can effectively implement a prevention strategy. These groups could utilise academic capacity within regional universities with experts who have the bandwidth necessary to help ICBs focus on the long-term agenda. The immediate demands on ICBs (from doctor strikes to A&E waiting times) otherwise hinder a sustained focus on inequity prevention. The evidence from Humber and North Yorkshire ICB is that there is an academic community willing and able to advise and support the ICB on such matters.

In summary, we need political leadership to drive coordinated public service delivery at a local level. This would ensure autistic CYP and their families receive the holistic care they need. The delivery of coordinated services requires the creation of formal partnerships at local authority area level. These partnerships can then enable services such as schools, health services, local authorities, voluntary services, faith leaders, and businesses to propel data driven, “whole system” approaches to improving outcomes for autistic CYP through schools and nurseries [24].

There is a role for central and local government to mandate and oversee such pragmatic approaches, providing challenge and support.

> **“Access to sort of a single source of information** whether that be service users or professionals or anybody else who might want to look at information around neurodiversity.”
>
> - Focus group participant

The role of educational psychology

Workforce issues will need to be addressed as part of the solution to the problems affecting autism assessment and support services.

Educational Psychologists (EPs), along with other professionals such as speech therapists and occupational therapists, play an important role in the support available to schools.

EPs can cotribute to supporting autistic CYP and their schools and families. They work with the 0-25 age range and support pre-schools, schools, and post-16 settings at the organisational level (e.g., providing training and helping with developing general systems of support), as well as working with individual children with and without a medical diagnosis. EPs work across settings providing transition support, including support with the transition to adulthood [85].

Autism-focused activities can form a large part of an EP's workload. They can work with schools to assess autistic CYP's needs; advise on or provide interventions and therapeutic work; provide training for staff and parents; work collaboratively with families, school staff and other services; support the development of the local autism strategy, such as autism assessment pathways; and some have specialist roles as part of autism diagnostic teams [86, 87].

Through their knowledge of individual schools and communities, EPs' school-based work can assist in developing staff knowledge of autism, for instance by helping staff to understand different presentations of autism such as autism in girls or co-occurring difficulties such as selective mutism, anxiety or emotionally based school avoidance [88, 89]. However, as young people have emphasised, this needs to be sustained support as an afternoon's training is not enough. EPs can help schools increase their capacity to meet needs through regular training and support with implementation of evidence-based approaches such as visual supports or social stories and by collaborating with school staff and families to develop individualised plans for pupils.

Increasing the number of EPs may potentially increase capacity for them to be able to focus on this important area of work, although there are concerns about continuing shortages. It is promising that since 2020 the Department for Education has increased the number of educational psychology training places available from 160 to 204 per year [90]. Nevertheless, EPs are leaving the service at a greater rate than they are being replaced and there are geographical inequalities impacting the availability of EPs in parts of the UK. For instance, there is no EP training provision within West Yorkshire, and this means that local authorities such as Leeds and Bradford struggle to recruit. Innovative approaches are required within the profession of educational psychology – such as the development of Masters level apprenticeship grades which enable graduates to apply their skills within schools under the supervision of a Doctorate level qualified EP.

Educational psychologists can help schools **increase their capacity** to meet needs through regular training and support.

End word

Evie
Shore

Jennifer
Shaw

Megan
Roker

Nat
Merrick

END WORD: Evie Shore, Jennifer Shaw, Megan Roker and Nat Merrick (The Research and Implementation Fellow Team from Born in Bradford's Centre for Applied Education Research)

As young people from the North of England, we are grateful that attention is finally being paid to the struggles and inequalities impacting CYP, with an immediate call for action. We are excited to have had the opportunity to contribute to this report and highlight the perspectives of young people, including those with autism.

One of the struggles which resonates with us most is the impact of the COVID-19 lockdowns and the effect they had on young people's educational experience. During this period, we experienced struggles with isolation, where we felt a lack of support and an absence of social interaction. CYP with autism and/or additional needs have been disproportionately affected by the COVID-19 pandemic and have faced additional barriers to accessing support during this time. Post-pandemic, the burden on health services because of this global crisis means CYP are unable to access support for many years, suffering with subsequent mental and physical ill health. The inherent inequalities and complexities of navigating autism pathways are leaving CYP and their families without the resources they need.

Having only recently exited the school system we can testify to the major role that school plays in a young person's daily life. We completely agree with this report's conclusion that the school system should be utilised to identify and support autistic CYP. Additionally, as teachers observe the behaviour displayed by CYP daily, their insights are invaluable when identifying individuals with unmet needs, as well as advising clinicians during autism assessments. Through working with the Centre for Applied Education Research (CAER) in Bradford, we have witnessed the need for place-based approaches, the importance of which is highlighted by the socioeconomic and cultural differences seen across the District. We also recognise that these developments must be evidence-based, using research and high-quality data. We have observed the success of using this approach in creating appropriate interventions that have real world benefits.

We wholeheartedly agree that working alongside autistic CYP is vital to ensure services are equipped to best support their needs. People with autism are best equipped to identify the challenges they face and propose efficient approaches. This can be seen in the toothPASTE project, helping support oral health through working with autistic CYP and their families. Psychoeducational resources produced with autistic CYP also highlight the importance of co-production; autistic CYP have often been wrongfully excluded from decisions about autism service provision, despite their expertise and insight.

Evie Shore: As part of the CAER team, and as a female autistic young person who has navigated the education system without additional support, I feel that the challenges I have personally experienced have been recognised by this report. It is refreshing to see so many practical recommendations be made, with the offer of an accessible needs-led approach. In the same breath, it is disheartening to discover the numbers of CYP who are being continuously failed by the system. The lack of awareness among healthcare professionals regarding how autism presents in girls is hindering CYP's chances of excelling in the classroom and beyond. Going for years unnoticed and without support can have profound negative effects on CYP's mental health considering the challenges of school transitions, and the complexities of secondary school social life. It is crucial to provide thorough training co-produced by CYP with lived experience, regarding the presentation of autism in girls, including what adjustments can be put in place to meet the needs of autistic girls earlier and more effectively.

> One of the struggles which resonates with us most is the impact of the **COVID-19 lockdowns** and the **effect they had on young people's educational experience.**
>
> We need a government who will put **CYP at the forefront of their decision making** and deliver the recommendations given by this report. **We need system-wide change, and we need it now.**

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Author list

Core writing team

Nabila Ali	Cardiff University
Anna Purna Basu	Newcastle University; Great North Children's Hospital
Sara Basuc	Fenland and East Cambridgeshire Priority Area
Caroline Bond	University of Manchester
Eleanor J. Bryant	University of Bradford
Emily Chapman	University of Leeds
Amrit Chauhan	University of Leeds
Samuel J.R.A Chawner	Cardiff University
Peter Day	University of Leeds; Bradford Community Dental Service
Emily Douse	Healthwatch York
Lucy Eddy	University of Bradford
Mai Elshehaly	City, University of London
Rai Fayette	University of Manchester
Melissa Gladstone	University of Liverpool
Kara Gray-Burrows	University of Leeds
Karen Guldberg	University of Birmingham
Sean Harris	Tees Valley Education
Calum Hartley	Lancaster University
Judith Lunn	Lancaster University
Prithvi Perepa	University of Birmingham
Rachel Pilling	University of Bradford
Lauren Powell	University of Sheffield
Pamela Qualter	University of Manchester
Judith Rankin	NIHR Applied Research Collaboration North East and North Cumbria; Newcastle University
Sue Robson	Newcastle University
Leanne Rogan	University of Leeds
Fiona Routh	University of Central Lancashire
Nikki Rutter	Durham University
Rebecca Salmon	Cambridgeshire County Council
Danielle Smith	University of Leeds
Kuldeep Sohal	Bradford Institute for Health Research
Lydia Gabriela Speyer	Lancaster University
Paul Sullivan	University of Bradford
Jacqueline Taylor	Cambridgeshire Community Services
Paraskevi Triantafyllopoulou	University of Kent
Marianne B.M. van den Bree	Cardiff University
Matthew Warburton	University of Leeds
Nicole Webb	Young Wellbeing Hub
Harriet Whitaker	Young Wellbeing Hub
Sarah Wild	Limpsfield Grange School

Editors

Mark Mon-Williams	Born in Bradford's Centre for Applied Education Research; University of Leeds
Evie Shore	Born in Bradford's Centre for Applied Education Research; University of Leeds
Megan L. Wood	Born in Bradford's Centre for Applied Education Research; University of Leeds

Core editorial team

Lydia Gunning	Born in Bradford's Centre for Applied Education Research; University of Leeds
Nat Merrick	Born in Bradford's Centre for Applied Education Research; University of Leeds
Mallory Morehead	Born in Bradford's Centre for Applied Education Research; University of Leeds
Lowri O'Donovan	Cardiff University
Alistair Quaile	University of Leeds
Megan Roker	Born in Bradford's Centre for Applied Education Research; University of Leeds
Jennifer Shaw	Born in Bradford's Centre for Applied Education Research; University of Leeds

Contributing experts

Christian Bunting	St Edmund's Nursery School; Bradford Birth to 19
Diane Daley	Bradford Teaching Hospitals NHS Foundation Trust
Nicole Dempsey	Dixons Academies Trust
Ava Green	Bradford District Care Trust
Jo Green	Centre for Young Lives
Margriet A. Groen	Lancaster University
James Lauder	Dixons Academies Trust
Margaret Nash	AWARE

Child of the North

N8 RESEARCH PARTNERSHIP

HEALTH EQUITY NORTH

CENTRE FOR YOUNG LIVES

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Clinical Priority for Neuro Development Assessments

Children and young people referred for neuro developmental (ND) assessment are routinely assessed in chronological order from date of receipt of referral, with the exception of those children and young people who are categorised as a clinical priority.

A local and regional clinical priority policy supports a consistent approach across providers. The policy would inform children, young people, parents and carers under which circumstances a neurodevelopmental assessment could be prioritised and provide reassurance that otherwise children and young people are assessed chronologically according to referral date.

The clinical priority inclusion categories describe children and young people were their level of risk and need was appropriate to require clinical prioritisation, whilst avoiding this being a significant number of children which would lead to an increase in waiting times significantly for all other children and young people referred for a ND assessment.

Clinical Priority Inclusion Categories

1. Children Looked After who are in an unstable family unit/placement at risk of breakdown
2. Asylum seekers
3. Children and young people under the care of the CAMHS Crisis team, where behaviour is escalating toward crisis
4. Any child or young person where there is a risk of breakdown of the family home necessitating social care involvement
5. Any child and young person who has been excluded from school despite an EHCP and reasonable adjustments being made
6. Children and young people under the Youth Offending Team
7. Children or young people on the Dynamic Support Register/Co-ordination

Consideration to the need for watchful wait for children and young people in the above clinical priority categories

The child or young person must be sufficiently clinically and psychologically stable to complete the assessment in order to determine an outcome. Some children and young people may require a period of watchful wait, with periodic review until their assessment can be commenced.

Where there is a high level of need a multi-agency approach should be taken to complete a holistic assessment with supporting agencies.

Exclusions to the above categories

Consideration was given to inclusion of the following categories; however it was felt the children and young people where the following apply would only be a clinical priority in the presence of one of the clinical priority inclusion categories above:

1. Looked after and adopted children and young people where the child or young person is in a stable family unit/placement.

Healthy
Minds

Bradford District and Craven
Health and Care Partnership
ACTasONE

Healthy Minds: our strategic plan for mental health, learning disability, neurodiversity, and substance use

Dear me

By Nicky J Rae

Mind in Bradford Creative Writing Group

Dear me, I know we've had disagreements,
and that we don't always see eye to eye.
But the last thing I want for you,
is to feel like you have to say goodbye.

Dear me, I know you've been hurting a long while,
and I know you're sick of the misery.
But just keep holding on a day at a time,
and someday you'll find yourself set free.

Dear me, I know you've been crying,
I've seen your demons give chase.
Smile inside for things will get better,
Wipe those tears from off your face.

Dear me, I know your heart is breaking,
like your being shattered in two.
But please - don't give up just yet,
for the survival rate is too few.

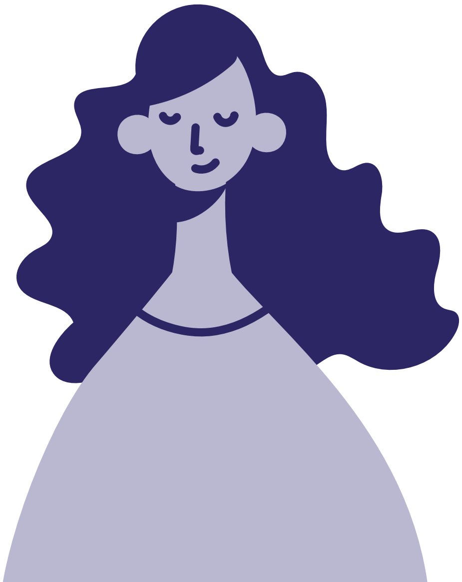
Dear me, I see that you are struggling,
that you feel like you're on the brink.
But keep pushing forward, keep fighting,
you're much stronger than you think.

Dear me, I feel so proud of you,
you've made it out alive.
You're happy now with all you've gained,
you've reached all things for which you strived.

Acknowledgements

We dedicate this strategy to the communities we serve across Bradford District and Craven. Our gratitude goes to everyone - people, carers, colleagues in frontline roles, operational and strategic leadership and our partners - for their support in helping to deliver this plan.

Table of contents



Executive summary: happy, healthy at home

Healthy Minds is our strategic health and care system approach, to achieve better lives and improve the support we offer to people with mental health, substance use needs, learning disabilities or are neurodiverse.

As a health and care system, we believe that when we ‘Act as One’ we can support people across Bradford District and Craven, with the best start in life and fulfil our shared purpose to ensure everyone can be ‘happy, healthy at home’. This ambition was set out in the Bradford District and Craven Health and Care Partnership Strategy[1] which was launched in 2022, where we set out our commitment to deliver for our population and our place by meeting people where they are, working with them to access the tools and opportunities to enable them to live longer in good health.

Our purpose

We Act as One to keep people happy, healthy at home

Our population

Supporting the delivery of our priorities and a better experience of health and care

Our place

Making our district the best place to live, work and study

Our partnership

Greater value through the best use of our collective resources, minimising duplication and waste

Where we live, study, work and develop relationships is important to ensure good mental and physical health and wellbeing. The coronavirus (COVID-19) pandemic has shone a spotlight on long-standing health inequalities[2] and the needs of our communities and we know that some communities struggled more than others. Our partnership approach led the way during the pandemic to come together, understand our population needs, build support and better access to care. As a district, we learned what is possible when we ‘Act as One’[3] to make a difference for people who need us the most.

Our Healthy Minds Strategy sets our plan to promote, respect and improve the wellbeing of everyone to be active citizens, but also to prioritise our efforts for people needing access to care and support for mental health conditions, substance use, neurodivergent needs or those living with a learning disability.

This strategy has three clear priorities to achieve this ambition:

1 **Promote better lives**
2 **respect rights; and**
3 **improve support.**

We established the Healthy Minds Board[4] to bring together health and care partners to jointly oversee and propel our commitment to achieving the best outcomes for our population. We do this by understanding need, setting strategy, measuring outcomes, clearly defining our objectives and priorities and aligning resources, managing risk and overseeing the development and delivery of the all-age integrated mental health transformation programme. This ensures we deliver on the NHS Long Term Plan[5] and statutory duties while maintaining a focus on prevention, protection, early intervention, and independence. This work will contribute to our West Yorkshire Integrated Care System[6] (ICS) partnership commitments.

We recognise the opportunities working closer together brings while making sure we understand and address the unique needs of individuals with mental health conditions, substance use issues, learning disability, autism and/or other neurodiverse needs. This strategy tries to be clear where appropriate on this distinction. We have learned a lot since we published our first partnership wellbeing strategy about being ambitious and dynamic, yet delivering on our commitments with realistic plans that are developed in partnership with people, our staff, and carers.

We all have a part to play in making Bradford District and Craven a great place to live, work and study. As a partnership board, our role is to work together and make the biggest positive difference possible to enable people to live brighter, better lives.

Thank you.

Councillor Susan Hinchcliffe
Leader of Council and Chair of the Health and Wellbeing Board
City of Bradford Metropolitan District Council

Iain MacBeath
Strategic Director, Adult Social Care and Health for Bradford Council
Director of Integration for Bradford District Care NHS Foundation Trust
Chair of Healthy Minds Partnership Board

Helen Davey
Co-chair of the Mental Health Provider Forum and Voluntary and Community Sector Lead for Mental health
Chief Executive, Mind in Bradford

Professor Mel Pickup
Place Lead, Bradford District and Craven Health and Care Partnership
(NHS West Yorkshire Integrated Care Board)
Chief Executive, Bradford Teaching Hospitals NHS Foundation Trust

Therese Patten
Chief Executive, Bradford District Care NHS Foundation Trust
Vice Chair of Healthy Minds Partnership Board

Dr Louise Clarke
Director of Strategy, Transformation, Primary, and Community
Priority Director for Healthy Communities Bradford District and Craven Health and Care Partnership (NHS West Yorkshire Integrated Care Board)

Healthy Minds – overview

Context

People living with mental health conditions, substance use, learning disability or neurodiversity experience poorest life expectancy and healthy life expectancy.

We will work together to meet increasing demand for support within a finite resource, delivering health and social care integration that is focussed on quality personalised outcomes for all.

Vision

Happy, healthy at home

Promote better lives

Support everyone with the opportunities to live an independent, fulfilling, healthier and longer life.

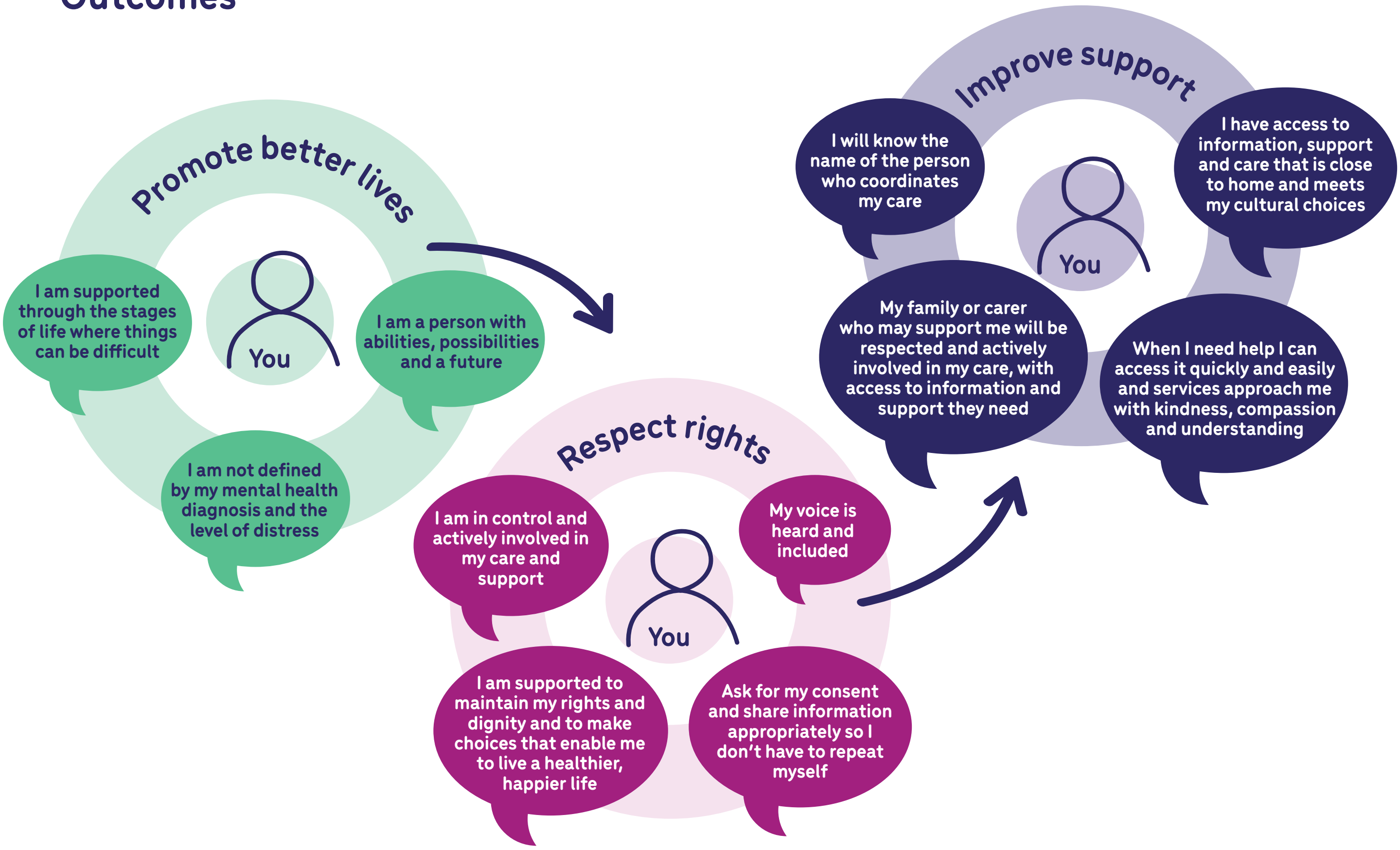
Respect rights

Involve people so they are informed to make choices and receive equitable access to opportunities.

Improve support

Support people with high quality, accessible, personalised care that promotes wellbeing.

Outcomes



Promote better lives

You

- I am supported through the stages of life where things can be difficult
- I am a person with abilities, possibilities and a future
- I am not defined by my mental health diagnosis and the level of distress

Respect rights

You

- I am in control and actively involved in my care and support
- My voice is heard and included
- I am supported to maintain my rights and dignity and to make choices that enable me to live a healthier, happier life
- Ask for my consent and share information appropriately so I don't have to repeat myself

Improve support

You

- I will know the name of the person who coordinates my care
- I have access to information, support and care that is close to home and meets my cultural choices
- My family or carer who may support me will be respected and actively involved in my care, with access to information and support they need
- When I need help I can access it quickly and easily and services approach me with kindness, compassion and understanding

Delivery framework

Support in your community
Healthy Communities

Support to live well
Community support

Support to get well
Specialist support

Support when you need it
Urgent and emergency care

Guiding principles

- Promote hope & better lives
- Happy, healthy at home
- Kindness and compassion in our approach
- Understanding awareness of trauma

- No decision about me without me
- Co-designed
- Challenge stigma and be inclusive
- Reduce inequalities

- No wrong door to services
- Easy to move between services
- Trusted shared assessments
- High quality recovery focussed care

System enablers

Living Well

Reducing inequalities

Estates

Data and outcomes

Research and innovation

Healthy Minds – promote, respect, improve

Bradford District and Craven is the fifth-largest metropolitan district in England spanning rural and urban areas and representing 25% of the West Yorkshire population. Younger aged people dominate a large population of Bradford, and the city has the third-highest population percentage for people aged under 16 years in England and there is a rapidly growing older population. A review by the Centre for Mental Health[7] highlighted the impact our demographics, housing, poverty, age, gender, and the COVID-19 pandemic has on people with mental health, substance use, neurodivergent needs or living with a learning disability. While we have challenges, the profile of both our population and district, bring with them opportunities and assets including diversity, entrepreneurship, resilience, creativity and ambition.

The lived experience of people and carers is at the heart of our Healthy Minds Strategy. We have listened to people, carers and staff sharing their journeys, their challenges and their aspirations for how our services must evolve and what we must hold on to that works well. They told us why these three priorities are important, what this looks like for them in practice and what our outcomes should be.

Promote better lives

Support everyone with the opportunities to live an independent, fulfilling, healthier and longer life.

Respect rights

Involve people so they are informed to make choices and receive equitable access to opportunities.

Improve support

Support people with high quality, accessible, personalised care that promotes wellbeing.

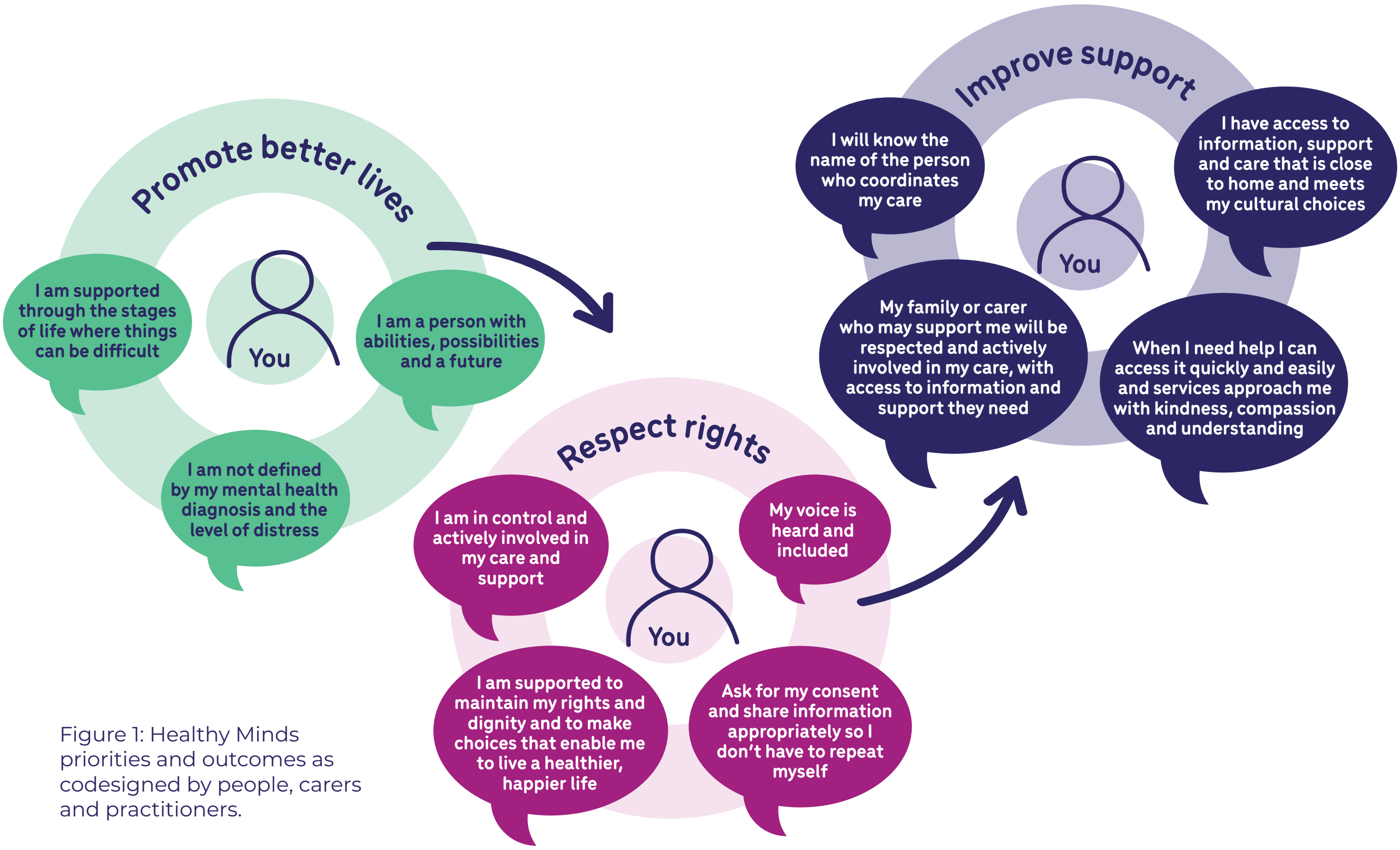


Figure 1: Healthy Minds priorities and outcomes as codesigned by people, carers and practitioners.

People with good mental wellbeing are more likely to have positive self-esteem, maintain good relationships, live and work productively and cope with the stresses of daily life. This is important for us all, but particularly so for people with substance use issues or those who live with a learning disability and/or autism who face many challenges to their resilience. Strong community infrastructure, a society that enhances rather than degrades mental wellbeing and high quality, accessible care services are extremely important in helping people maintain their mental wellbeing and be active citizens.

One in four people across Bradford District and Craven will suffer from poor mental health at some point during their lives and those with a severe illness can die up to 21 years earlier than the rest of the population. The life expectancy gap for people with a learning disability is 33 years with the average age of death being 52 years, 48% of people die in hospital and only 21% where they usually live. Forty-eight per cent of people have five or more chronic health conditions[8]. Having a learning disability increases the likelihood of experiencing deprivation and poverty, and evidence shows being autistic limits the chances of people being able to work and look after their own health. The life expectancy gap for autistic people is approximately 16 years on average compared to the general population and almost 80% of autistic adults experience mental health problems during their lifetime[9]. People with substance use issues are more likely to have one or more long term chronic condition and experience barriers to access and support. For many people, mental health problems begin in childhood but stay with them and their families for life. Poorer mental health is often associated with higher rates of smoking and substance use, decreased social relationships and resilience.

We know that people with mental health conditions, or with substance use issues or those who live with a learning disability and/or autism experience social and economic disadvantage, prejudice, and exclusion resulting in poor health outcomes through their life journey.

In 2019, we held a ‘big conversation’ where people across Bradford District told us they wanted somewhere to live where they feel safe and have their own front door, paid employment in an interesting job where they have colleagues and friends, someone to love, a relationship, family, the opportunity to talk about their hopes and dreams and make these happen. Together, we want to improve and promote our services, ensuring the rights of people and carers are respected and their voice is at the centre of our strategy and plans, so that everyone can live happy, healthy at home, with better lives and brighter futures.

We know people’s lives are better when the organisations who provide health and care work well together, particularly at the times when people most need support. We also know that sharing good ways of working makes our resources go further, creates the best use of staff expertise and increases the quality and range of what we provide. This is our blueprint to unify everyone in delivering our vision for this priority population.

Joining up mental health, learning disability, neurodiversity and substance use

People do not fit into single categories, we all have several inter-connected aspects of our life across gender, race, conditions or responsibilities. Bringing these distinct areas together under one strategy will help strengthen our understanding of common challenges for people with these conditions. This includes challenges faced by individuals and their carers, helping services make reasonable adjustments for people who need it, and ensuring access to physical health services, education and employment opportunities. We must also continue to address the unique needs of individuals with mental health conditions and substance use issues, learning disability, autism or other neurodiversity. This strategy tries to be clear where appropriate on this distinction.

Throughout this strategy we recognise that Bradford District and Craven has excellent areas of practice and innovation to be proud of, yet we also know that there are areas of improvement, gaps and inequalities that we need to address. This strategy describes why we are making the improvements to services in our local places and across the health and care system, what will be different as a result, and how the partnership plays its role as part of delivering our ambitions.

Our health and care organisations are working together to reduce the variation and inequalities in life expectancy and service provision. We will make a dedicated effort to prioritise people with mental health conditions, living with a learning disability, neurodiversity or substance use issues - particularly for those in minority groups or those facing additional barriers due to wider social factors as we recognise their challenges in comparison to the wider population. By using our collective expertise, money, staff and facilities we can improve outcomes; seeing fewer people in crisis, fewer people reliant on inpatient services and fewer people left behind without the support they need to lead a fulfilling, flourishing life.

If we do this, what will be different...

Better lives **Respect rights** **Improve support**

- **No gaps – services designed for people**
- Integrated working
- Better transitions

Partnership

- Easy to **access**
- Reduced waiting times
- Needs-led not diagnosis-led

Population

- Right care, right time
- High **quality** care
- **Valued workforce**

Place

- Support and care close to home
- **Clear defined support routes**

Purpose

Act as one to keep everyone happy, healthy at home

Our strengths

Our communities

Community life, social connections and having a voice in local decisions are all factors that support good health and wellbeing. These community level determinants build control and resilience and can help buffer poor health and promote better health. We celebrate community diversity and are proud to be a City of Sanctuary that welcomes new people.

Education

Being in education, employment or training or learning new skills are associated with a reduced risk of a range of negative mental and physical health outcomes, as well as better employment prospects.

Health and care

We have a strong health and care economy which delivers specialist care and support. We are known for our innovative public services, a vibrant voluntary and community sector and powerful data and analytics through our Born in Bradford research powerhouse.

Culture and arts

Arts and culture have a positive and healing impact on wellbeing. Our district boasts a strong cultural, agricultural and arts heritage, and as a district we will be the City of Culture UK in 2025 with an impressive celebration boosting our presence and identity.

Economy and enterprise

Bradford is home to 16,600 businesses, over 4000 voluntary and community services and a £12bn economy. We are the UK's number one levelling up opportunity and we are progressing an ambitious pipeline of projects designed to benefit all our population.

Faith and spirituality

Faith and spiritual practices can play a strong positive health factor for many people. Across our district, we have a strong multi-faith partnership that provides support, connectivity and resilience for communities and neighbourhoods.

Partnership working

Our strategic partnerships are excellent. The distributed leadership model in our place and our widely known 'Act as One' approach means Bradford is a place that other systems visit for advice and learn from our partnership-led approach.

Open spaces

We are fortunate to have a range of open green spaces throughout our urban and rural areas and our district covers 142 square miles for Bradford and a vast 453 square miles in Craven. We are one of the few cities outside of London to establish a Clean Air Zone.

Food industry

Easily accessible and nutritious food can reduce health inequalities, improve health and wellbeing. We have a strategy that aims to raise the profile of good food and create a secure and sustainable food supply chain that strengthens our local economy.

Our challenges

Population

We have a population of 657,579 people including around 50,000 living in Craven. Half of our people live in the city of Bradford, the rest live in the small towns and rural areas of Craven and the Aire and Wharfe valleys in the north of our district across a landscape that brings transport and connectivity challenges.

Life expectancy and healthy life expectancy

The maps below of Bradford District and Craven highlight the variation for both life expectancy and healthy life expectancy. Across our district, life expectancy varies in average by 9.6 years and for the population with severe mental illness or with autism can vary up to 16 years, while for learning disability by as much as 21 years (Figure 2a). Equally alarming is that the healthy life expectancy of the general population can vary by 20 years but for people with a severe mental illness or learning disability, this can vary between 20 and 33 years (Figure 2b).[10]

Deprivation

We have persistently high levels of deprivation and our District is England's fifth most income-deprived area. More than a third of our population live in poverty. Almost a third of children are eligible for free school meals. Whilst wards around central Bradford and Keighley appear in the 10% most deprived wards in the country, wards in the Wharfe Valley are in the 10% least deprived nationally.

Housing

Housing has a big part to play not only in improving health and wellbeing, but also in improving financial stability for households. A third of our houses were built before 1910s and we not only need new good quality housing, but homes for a diverse population with differing needs. This includes homes for larger families and those which meet cultural needs, homes adapted for people with disabilities and homes which are inclusive and accessible for a range of needs and changing circumstances.

Figure 2A: Life expectancy

Figure 2B: Healthy life expectancy

Employment

The proportion of the working age population is lower in Bradford than the average for England. The impact of financial pressures and cost of living are putting pressure on some of the poorest communities across our District. Weekly wages are £68 below the national average and unemployment is above average. In-work poverty has increased in the city above average to elsewhere in England. Financial insecurity has huge implications for people's mental health and life expectancy and is the largest single factor that perpetuates mental health inequality.[11]

Children and young people

Almost 40% of children live in the poorest areas, 20% of households are four times more likely to have serious mental health difficulties by the age of 11. Locally our children's services have 1587 children who are looked after and 6190 children open to children social care services – these figures are almost double national averages. Born in Bradford data shows higher than national average number of children with anxiety and depression. The health inequalities for children with learning disability and neurodiversity are widening.

Education

We have an educational attainment gap between Bradford and the rest of the country that persists and the number of people with good qualifications is relatively low. 4093 children and young people have an education, health and care plan (EHCP), 14,044 children and young people have a Special Education Needs support plan and 31% of children at age six are not school ready.

Investment

National funding, and local prioritisation, has historically seen mental health, learning disability, substance use and autism services under-funded. The Mental Health Investment Standard seeks to protect investment however, it is not in line with population need, rising demand or wider context of children's services and social care pressures and subject to cost-saving exercises which target mental health disproportionately as 'easy to identify' savings. Our local economy has declared a deficit budget and this will further impact on our services and communities. More work needs to be done to ensure we invest further in support for children, minority communities and trauma-informed support.

Workforce

There are significant challenges with recruitment and retention of our health, care and community sector workforce and the pandemic has had a negative impact on the wellbeing of staff. Specialist and skilled training places and access to training for our future workforce is a national issue too.

Estates

The lack of available estate and equipment to address increasing demand and the management of people in the community is a challenge. There are some specific constraints around our existing estate that need to be managed and support our ambitions to integrate and co-locate our staff and services.

Demand

There is an increasing demand for all health and care services and our population is presenting to services with more complex conditions. Managing this alongside our targeted work to address the backlog from the COVID-19 pandemic has resulted in significant system pressure.

COVID-19

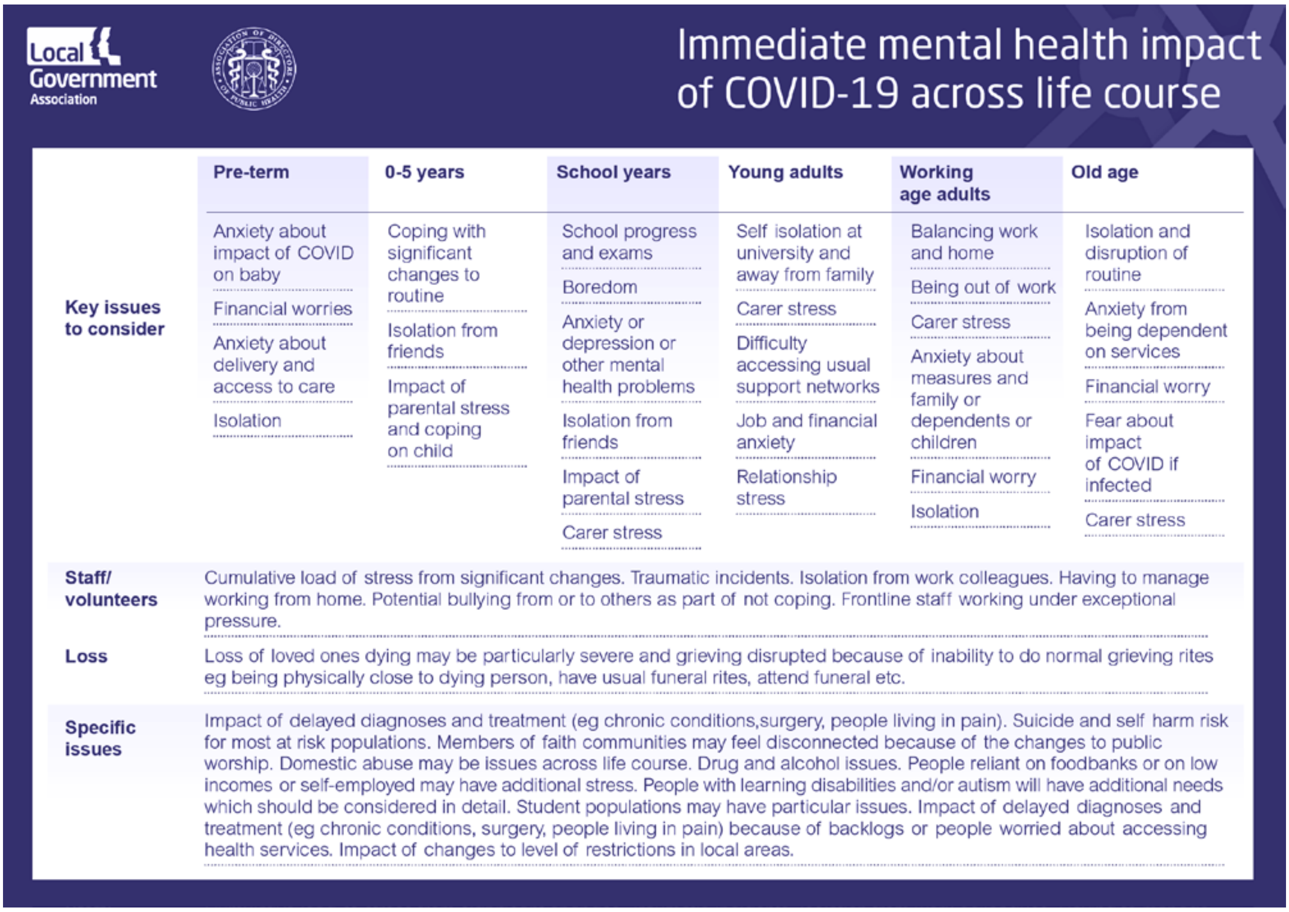
Across Bradford District and Craven, we witnessed a strong partnership between communities and services during the COVID-19 pandemic. While many people have acted in solidarity, and there are some positive benefits from this community spirit and response, evidence shows that the pandemic is having a detrimental impact on the mental health of some people and the widening of health inequalities for people who experienced challenges before the pandemic.

Young in Covid[12], a series created by young people, provides an account of how lockdowns and Covid restrictions have impacted young people in Bradford and explores some of the ways in which young people have found solutions to their problems and looks at ongoing issues such as mental health.

Our work on our Rapid Needs Review[13] - and the subsequent partnership delivery of support-established learning and good practice for changing and transforming the way we engage, support and care for people and is the foundation of our 'Act as One' ethos.

Locally, we know that the number of people seeking help via our child and adolescent mental health services (CAMHS) has increased by 32% and our Talking Therapies services by 24% than before the pandemic. Our Community Companions service which supports older people with mental health conditions or learning disabilities and our wellbeing, counselling and Safe Spaces have all seen an exponential rise in their referrals. Our services are not seeing demand return to pre-pandemic levels.

The behaviours and environments needed to curtail the spread of COVID-19 are known risk factors for mental health difficulties. The diagram below shows potential health impacts of COVID-19 across the life course which we will factor into our programmes of work.



Local Government Association

Immediate mental health impact of COVID-19 across life course

	Pre-term	0-5 years	School years	Young adults	Working age adults	Old age
Key issues to consider	Anxiety about impact of COVID on baby Financial worries Anxiety about delivery and access to care Isolation	Coping with significant changes to routine Isolation from friends Impact of parental stress and coping on child	School progress and exams Boredom Anxiety or depression or other mental health problems Isolation from friends Impact of parental stress Carer stress	Self isolation at university and away from family Carer stress Difficulty accessing usual support networks Job and financial anxiety Relationship stress	Balancing work and home Being out of work Carer stress Anxiety about measures and family or dependents or children Financial worry Isolation	Isolation and disruption of routine Anxiety from being dependent on services Financial worry Fear about impact of COVID if infected Carer stress
Staff/ volunteers	Cumulative load of stress from significant changes. Traumatic incidents. Isolation from work colleagues. Having to manage working from home. Potential bullying from or to others as part of not coping. Frontline staff working under exceptional pressure.					
Loss	Loss of loved ones dying may be particularly severe and grieving disrupted because of inability to do normal grieving rites eg being physically close to dying person, have usual funeral rites, attend funeral etc.					
Specific issues	Impact of delayed diagnoses and treatment (eg chronic conditions,surgery, people living in pain). Suicide and self harm risk for most at risk populations. Members of faith communities may feel disconnected because of the changes to public worship. Domestic abuse may be issues across life course. Drug and alcohol issues. People reliant on foodbanks or on low incomes or self-employed may have additional stress. People with learning disabilities and/or autism will have additional needs which should be considered in detail. Student populations may have particular issues. Impact of delayed diagnoses and treatment (eg chronic conditions, surgery, people living in pain) because of backlogs or people worried about accessing health services. Impact of changes to level of restrictions in local areas.					

Working together – our principles and framework

Our ambition is to move away from a system that is based on thresholds and tiers to enable people to access information, advice, support and care based on their needs.

Working together with people accessing our services, their carers, with staff and partners we shared experience and expertise on understanding how we improve the support available. The result is we have adopted, and adapted, the evidence-based model called i-Thrive[14] to provide a whole system approach for our services to support children, young people, adults, and older adults to be happy, healthy at home and have agreed a series of clear guiding principles to deliver and improve our support.

Each of the groupings are distinct in terms of the needs and/or choices of the individuals and enable us to ensure we have the right workforce, with skills that mix, and resources required to meet the needs and choice of people. We will underpin this with our focus on public health, addressing inequalities and maintaining mental wellbeing through effective prevention and protection strategies that are community-based.

Healthy communities

It is easier to get advice and support where you live with the things that impact your mental health and wellbeing.

Community support

You will have easier access to the right support for your wellbeing, mental health and physical health when and where you need it.

Specialist community support

Our specialist and focused care to support you to recover and live well, whether you're in hospital, residential care, supported accommodation or at home.

Urgent and emergency care

Our urgent and emergency care will provide round the clock support and care that you need when you experience a mental health crisis.

Guiding principles:

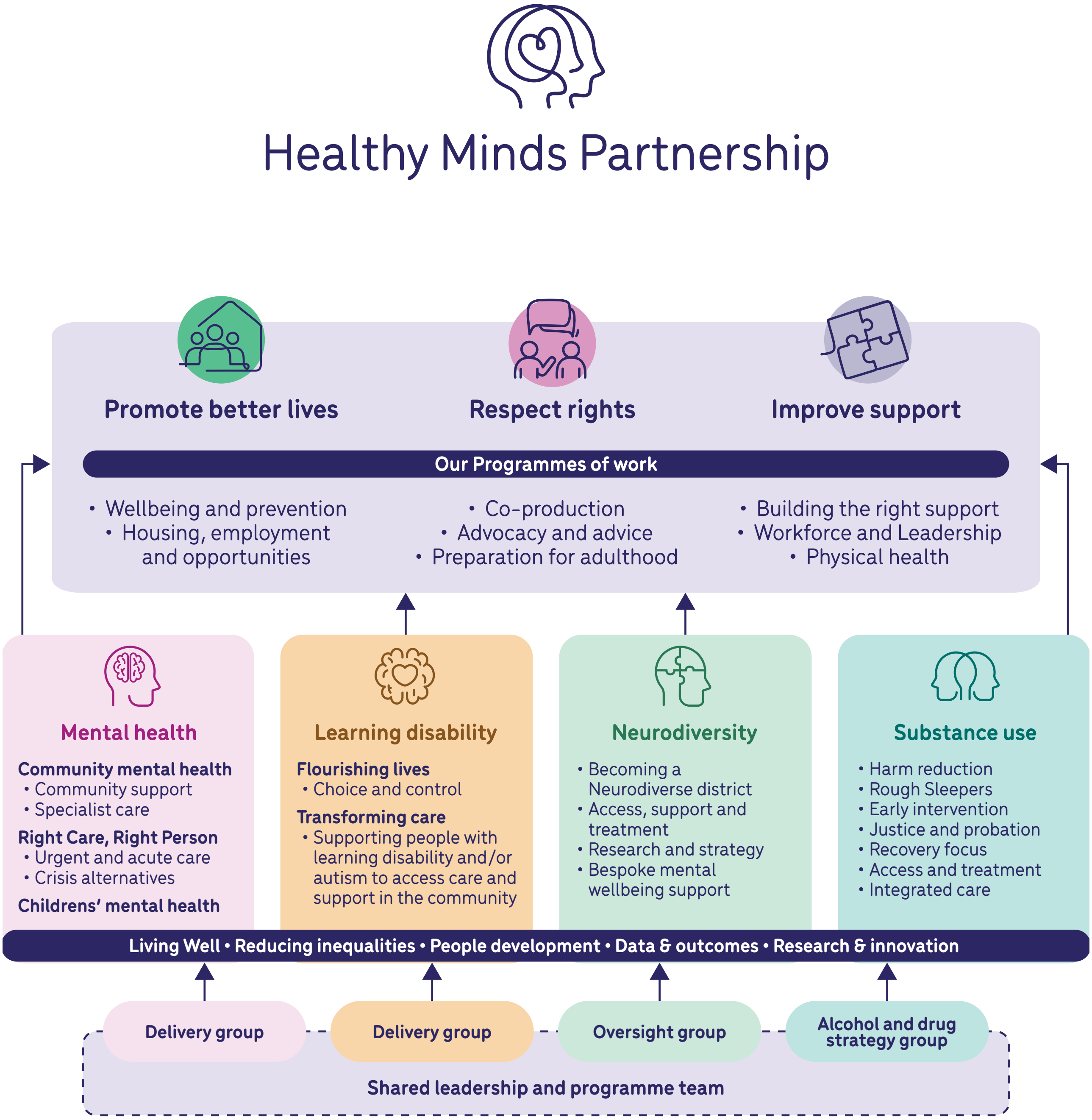
Promote better lives	Respect rights	Improve support
Promote hope & better lives	No decision about me without me	No wrong door to services
Happy, healthy at home	Co-designed	Easy to move between services
Kindness and compassion in our approach	Challenge stigma and be inclusive	Trusted shared assessments
Understanding awareness of trauma	Reduce inequalities	High quality recovery focussed care

Figure 3: Our framework and guiding principles codesigned by people, carers and practitioners

Our Healthy Minds programmes

Figure 3 (on page 14) sets out how the Healthy Minds Partnership will deliver our work, both meeting the statutory commitments and improving our services through transformation and investment. It is a framework that easily enables integration with our wider health and care partnership priorities to ensure we are holistically supporting the health and care needs of people of all ages. The principles, co-designed with partners and those who are involved In receiving our services, to make sure we are guided by what matters.

If the above provides the 'how' we will deliver our priorities, then the below diagram provides a description of what we will do. It is a high-level overview of what approach and areas of work we have.



Healthy Minds Partnership

Promote better lives

Respect rights

Improve support

Our Programmes of work

- Wellbeing and prevention
- Housing, employment and opportunities

- Co-production
- Advocacy and advice
- Preparation for adulthood

- Building the right support
- Workforce and Leadership
- Physical health

Mental health

Community mental health
- Community support
- Specialist care

Right Care, Right Person
- Urgent and acute care
- Crisis alternatives

Childrens' mental health

Learning disability

Flourishing lives
- Choice and control

Transforming care
- Supporting people with learning disability and/or autism to access care and support in the community

Neurodiversity

- Becoming a Neurodiverse district
- Access, support and treatment
- Research and strategy
- Bespoke mental wellbeing support

Substance use

- Harm reduction
- Rough Sleepers
- Early intervention
- Justice and probation
- Recovery focus
- Access and treatment
- Integrated care

Living Well • Reducing inequalities • People development • Data & outcomes • Research & innovation

Delivery group

Delivery group

Oversight group

Alcohol and drug strategy group

Shared leadership and programme team

Figure 4: Our Healthy Minds programme structure

Mental health

People's mental health and wellbeing can change and anyone can develop a mental health problem. But the factors that increase the risk of poor mental health or promote good mental health, are not distributed equally across our district. This means that certain communities or groups are more likely to have poor mental health and to find it more difficult when they try to get help.

We held a Healthy Minds summit in 2019 and have set out our ambition to move away from siloed, hard-to-reach services towards joined up care and whole population approaches that established a revitalised purpose and identity for mental health services. And while we have delivered some excellent, award-winning work, we know more needs to be done around three big areas: community mental health, acute care settings and children and young people's mental health.

The overall ambition is to enable support, closer to where people live, promoting easy access rather than automatically referring people onto mental health teams and into other organisations as a gateway into secondary care.

Developing priority actions

Delivering our NHS Long Term Plan requirements means we've made some progress to improve our services. The protected investment gave an opportunity to address the historic gaps in service investment and work towards radically changing the design of community mental health care.

We have established programmes of work that aim to transform the present offer and it is not envisaged that these will stop as we strive for better mental health for everyone. This includes looking to strengthen the early help and preventive offer, developing our community mental health services and transforming the way we deliver acute and emergency support for people presenting with mental health crisis. Our Healthy Minds Partnership Board is vital in progressing this and we will establish an Alliance structure, in keeping with our West Yorkshire partners, to deliver our ambitions.

Reducing stigma, developing trust within and between communities, improving services, and working across organisational boundaries to meet people's physical and mental health needs, is dependent upon changing how we think and feel about mental health and relies upon organisations and systems working together in new ways.

What have people and carers told us about services that we need to address:

- People stuck between primary care and secondary mental health services
- People not ‘fitting into boxes’ and needs not being met
- Long waiting times, referrals going to wrong service, multiple assessments and hand offs – pathways and service exclusions are not working for our population
- Lack of sufficient evidence-based treatment and psychological therapy waiting lists
- People being seen and described as a “risk”
- People struggling to access support for wider determinants e.g., housing, money, employment, social support and early help
- Physical health inequalities and poor physical health outcomes.

What we will do:

Promote better lives

Promote wellbeing and supporting people to live an independent, healthier and fulfilling life with the aim helping people being part of their local communities.

Respect rights

Deliver community led support that promotes choice and centres the respect and dignity of people to reduce inequalities and uphold their Human Rights.

Improve support

- We will establish new and integrated models of primary and community mental health care to support adults and older adults who have severe mental illnesses, so that they will have greater choice and control over their care and be supported to live well in their communities
- We will establish more comprehensive 24/7 mental health crisis services across our district that are able to meet the continuum of needs and preferences for accessing crisis care, whether it be in communities, people’s homes, emergency departments or inpatient services.

Healthy communities

We’re making it easier to get advice, guidance and practical help where people live with the things that can support their mental wellbeing within their communities.

- Promote and develop services that are hyper-local and support people reach for their hopes and dreams and connect to opportunities that make these happen
- Support the coproduction and mobilisation of the Core Model[15] in alignment with Healthy Communities
- Promote our Healthy Minds online ‘Support finder’ to offer people advice and information (available through www.healthyminds.services)

Community support – supporting people to live well

People will have easier access to the right support for their mental and physical health, and wellbeing in their community when and where they need it.

- Connect a range of multi-professional and multi-agency teams to deliver needs led support when people need it and support them to maintain their wellbeing.
- Drive the improvements to embed the severe mental illness (SMI) physical health pathway
- Develop and implement referral pathways with substance use, domestic abuse and advocacy services
- Design a system approach to the personalised co-ordination of care (moving away from the current Care Programme Approach[16] (CPA) arrangements)
- Carers support and prevention.

Specialist community support – supporting people to get well

Our specialist and focused care supports people to recover and live well, whether they're in a hospital rehabilitating, residential care, supported accommodation or at home.

- Personalised care met by a multi-disciplinary team from the different social and health care, and voluntary and community sector organisation
- Eating disorders: support the development of our community-based integrated eating disorder offer focussing on early intervention and improved physical health monitoring
- Community rehabilitation: support a review of the current pathway and make recommendations to develop community and specialist rehabilitation offers that offer integrated health and care support
- Complex emotional needs: develop and improve pathways for people to receive specialist trauma informed support
- Increase and diversify the workforce including new roles.

Urgent and emergency care

Deliver 24/7 urgent and emergency care that will provide people the support they need when they experience a mental health crisis

- Support the move to an integrated urgent care mental health telephone crisis and support line
- Support the development of a clear plan to support 111 mobilisation and align pathways with community mental health services and specialist rehabilitation support
- Deliver a crisis house offer and expand our safer space offers that provide people with alternatives to crisis admissions and emergency visits
- Design our mental health liaison to be an all-age service so that any person experiencing a mental health crisis in an acute setting receives the appropriate response or outcome to meet their needs and have an evidence-based care package
- Increase our in-reach support, reduce inpatient admission stays and eliminate out of area placements.

What will be different?

- Joined up services with a skilled and confident workforce
- Improved access and reduced waiting times to evidence-based interventions based on need
- High quality personalised services that promote independence and recovery, and
- Support that is close to where people live.

Spotlight – Bradford Crisis House

The Bradford Crisis House is an alternative to a hospital admission for adults over 18, who live in Bradford District and Craven, whose recovery would be better supported in a residential community setting. This is a partnership between Bradford District Care NHS Foundation Trust, social care (Bradford Council) and Creative Support (a community sector organisation).

In the first 10 weeks of opening, the service welcomed 20 people, the average length of stay was five days and 19 people did not require an ongoing hospital admission. The house provides a safe, homely space where guests receive therapeutic short-term support when experiencing a mental health crisis. The service has been co-designed by people and has been a long ambition expressed by people who have experienced crisis admission in the past.

Crisis support workers are available to support guests 24/7 during their stay, helping them throughout their crisis. In addition to this support, all guests have a daily one-to-one contact session with the Intensive Home Treatment Team (IHTT) workers. This partnership between IHTT and crisis support workers, ensures guests receive the appropriate therapeutic support during their stay, and that the correct follow-on support is set up when guests leave the service. People can stay for up to seven days.

Some of the presenting reasons for people's crisis were:

- suicidal thoughts
- recent trauma
- low mood and anxiety
- loss of job
- bereavement
- psychotic symptom
- feeling unsafe at home
- self-neglect
- depression
- end of relationship
- intrusive thoughts

Feedback by people who have stayed include:

"My time here has been really helpful; staff have been really empathetic and non-judgemental. Staff have provided helpful distractions and techniques to help regulate my emotions."

"Very good time, appreciate all the support and help. Nice environment and people. Great caring staff who are very helpful and are always wanting to support. I feel calmer after this experience, a big thanks to all the staff working here, legends."

"I have been well looked after, staff are very professional and supportive. Lots of time spent listening to me and providing reassurance and life direction."

Children and young people's mental health

In 2020, we carried out a system review[17] of our mental health support for children and young people. This highlighted key areas of need and good practice and a clear plan for improving the support we offer to children, young people and families. Brighter Futures is our plan of work, and we will continue to deliver on the recommendations set out in the report and transform services in line with the NHS Long Term Plan. This Healthy Minds Strategy gives us an opportunity to pause, reflect and align our efforts in achieving the outcomes and to further the aims of Future in Mind, the national strategy that focuses on children and young people's mental health and wellbeing.

Promote better lives

A focus on prevention, early help and enabling positive mental wellbeing and greater opportunities to thrive at school or at home.

Respect rights

Involving children, young people and families, supporting informed choice, and keeping children safe.

Improve support

Improve access to evidence-based support, integrating children's mental health services with a needs-led outcome focus using the i-Thrive model.

i-THRIVE takes a needs-led approach to support, has the voice of children and young people at the heart of decision making and focuses on creating a proactive prevention offer based on collaboration and partnership working.

Children and young people's mental health

Healthy Communities (Thriving)

Prevention and promotion: Work with communities, children and young people to co-create what works to protect their wellbeing

Healthy Minds in Schools: Whole school approaches with our Healthy Minds resource pack for schools, Healthy Minds champions, charter, wellbeing practitioners and support teams

Support in your community (Get advice)

Healthy Minds website (www.healthyminds.services): Our digital doorway to information, advice and support and embed this with Living Well Schools

Support to live well (Get help)

Easy access: Implement the i-THRIVE framework and establish a one front door for accessing support

Support to get well (Get more help)

Improve waiting times and range of support

Support when you need it (Urgent support, risk and safeguarding)

Focus on children who need more support and have trauma informed approaches.

What will be different

- We will increase the early intervention and prevention approach for children and young people
- We will join up services, so children and young people experience seamless care and support
- We will reduce waiting to access evidence-based support
- We will support children, young people and families to live their full potential.

Spotlight – Know Your Mind

Ten-year-old Asian British boy, Sanjeev* was referred to the Know Your Mind (KYM) service through our joint worker in primary care. He was experiencing pains in his body caused by anxiety and was unable to attend school. He was on a reduced timetable of two half days per week. Sanjeev had experienced separation trauma in 2021 when his mum remarried and he had to leave his home and move in with his dad and half-brother with whom he had a turbulent relationship.

During Sanjeev's "get to know you" session with his KYM worker, he explained that he was struggling to sleep, experiencing high levels of anxiety and having distressing thoughts about death. Using the goals-based outcomes (GBO) self-rated outcome measure, Sanjeev set a goal with his KYM worker to "return to school and feel more confident there" and rated current state as 2/10 at the start of support.

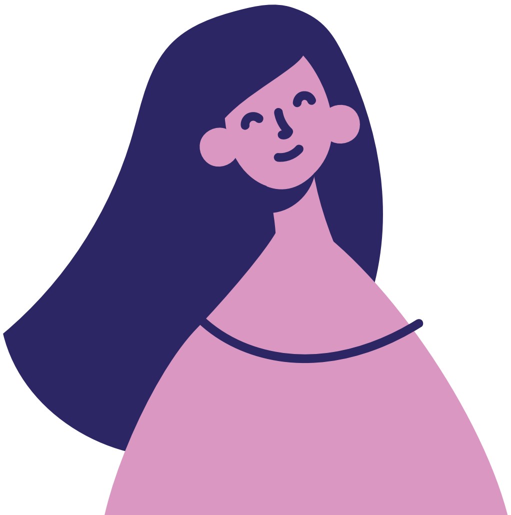
Sanjeev and his KYM worker worked alongside mum, dad and the school nurture team, tailoring our approach around Sanjeev's goal. Over a period of eight weekly one to one sessions, the KYM worker engaged Sanjeev in a range of activities that "got him into his body", reflecting and addressing trauma. This included physical games, drama-based grounding exercises, voice work for confidence, breathing exercises to help regain control of heightened emotions and psychoeducation around intrusive thoughts, anxiety and the physical effects of anxiety. They also did work together with Sanjeev, dad and school staff around boundaries and confidence-building within the home and school settings.

At the end of the eight week support with KYM, Sanjeev had made significant progress towards his goal; he is now attending school on a full-time schedule, is always on time to school, is feeling happy in his friendship circle and is excited about transitioning to year 6. He stated that he no longer experiences pain in his body and has improved his relationship with mum and dad. He also stated that he no longer thinks about death and instead thinks about the universe and questions relating to life and recognises that these are "existential thoughts" which lots of people with great minds think about.

Sanjeev rated his progress against his goal at the end of support as 9/10, an increase of +7 from the 2/10 he rated the goal at the start of support. The reliable change index (indicating statistically significant change) for GBO is +3 or more. Sanjeev also gave all of his support sessions with his KYM worker a 5/5 satisfaction score and stated, "It's been really fun and now I know about all the different types of emotions and what I can do to feel better".

Know Your Mind is a service delivered by our Youth in Mind lead provider, Mind in Bradford.

*Names have been changed for confidentiality.



Learning disability

People with learning disabilities have the same aspirations as everyone else – to be happy and healthy at home. Evidence suggests people with a learning disability have a much shorter life expectancy than the general population - with six out 10 people with learning disabilities dying before the age of 65, compared to one out of 10 for people from the general population. Those with epilepsy and from minority ethnic backgrounds were more likely to die younger[18]. This means we need to ensure that not only are health services making reasonable adjustments to ensure that they are accessible to everyone but that as a district we are supporting people with learning disabilities to live as healthy a life as possible, making sure they have access to employment, good housing, physical activity and can enjoy choice and exercise their rights.

The NHS Long Term Plan identifies that work will be done to tackle causes of morbidity and preventable deaths for people with learning disabilities. There is also a focus on ensuring people with a learning disability can live in the community, with the right support[19]. This means we need to provide accessible, equitable and empowering opportunities for people of all ages in all areas of their lives.

Promote better lives

- Help people with learning disabilities to achieve their aspirations
- Work together to reduce health inequalities and therefore the number of preventable deaths

Respect rights

- Uphold people’s rights
- Work with people with lived experience prioritising co-production in our work

Improve support

- Ensure that people get the right support at the right time in their local community or least restrictive setting
- Build strong connectivity with health and care services, to support safe and effective transitions
- Work in partnership with providers from both the independent and voluntary sector to improve access to support

The overarching focus for our programme is to reduce health inequalities, we will work to reduce the gap in life expectancy for people with learning disabilities. This includes goals such as ensuring that 75% of people aged over 14 on the primary care learning disabilities register will have an annual health check and accessible health action plan. We continue to work to this target and achieved it in 2022/23 and this will continue to be a priority across the District.

The STOMP and STAMP (stopping over medication of people with learning disabilities) programmes are also key areas of work for both children and adults with learning disabilities, with antipsychotic prescribing rates higher in these populations than those without learning disabilities. This prescribing can be appropriate at times, but to ensure this is the case, regular medication reviews are required, and medication should never be seen as the first port of call – for many people having choice and control over their lives can help reduce the need for medications.

Our services continue to evolve to reflect the findings from our local Learning Disability Mortality Review (LeDeR) reports, engagement with the Learning Disabilities Improvement Standards within NHS trusts and the roll out of the mandated learning disabilities and autism awareness training, across all Care Quality Commission regulated providers. This will continue to help improve awareness across services of the need to make reasonable adjustments in order to support people with learning disabilities to access the right support at the right time. This should reduce barriers to services such as routine cancer screening offers, or hospital admission pathways that can at time make it difficult for people to get the health care they need.

To deliver this work we are focusing on several cross-cutting areas, improving early intervention and prevention (particularly for age range 0-25 years), market development (including more housing options), service developments and increasing workforce capacity and capability.

Healthy communities

Flourishing lives - we will work with people with learning disabilities so that they have choice and control, can exercise their rights, and meet the outcomes they want to achieve in areas that are important to them.

Support to live well

Building the right support - we will review our commissioned services to improve early intervention services, identify any gaps or duplication, develop more housing options, to ensure people have the right support in the right place, at the right time.

Physical health - stopping over medication of people with learning disabilities and improving the physical health of people with learning disabilities.

Preparation for adulthood - we will work across the system, to ensure smooth transitions for young people, as they prepare for adulthood.

Support to get well and support when you need it

Transforming Care – we will reduce inappropriate hospital admissions and the number of people with a learning disability in locally commissioned inpatient settings through access to joined up community services and effective crisis support. This will include having good local resources in place and access to specialist support as required (including robust Care and Education Treatment Review (CETR), Care and Treatment review (CTR) and Dynamic Support Register (DSR) systems).

What will be different

- People with learning disabilities can access universal health services through reasonable adjustments and all have accessible health action plans.
- Improved health and outcomes of individuals with learning disabilities.
- More people are accessing support within their local communities and living independently.
- There will be a wider range of support and accommodation options for people with learning and physical disabilities.
- More people will have Direct Payments and Individual Service Funds.
- We will reduce the number of avoidable admissions to our Assessment and Treatment Unit (ATU).

Spotlight – Respiratory Pathway and Keeping My Chest Healthy Digital Hub

In response to the high rates of respiratory issues for people with learning disabilities highlighted by Learning Disability Mortality Review (LeDeR), Bradford District Care NHS Foundation Trust (BDCT) clinicians supported by the Working Academy at the University of Bradford worked in partnership with people with learning disabilities, their families and carers to co-produce a digital resource.

The respiratory pathway and website will support people to manage their respiratory health at home by providing of suite of accessible videos and text guidance available in multiple languages. The site is enabled for use on both tablets and phones and can be accessed by scanning the QR code that is embedded in an individual's Keeping My Chest Healthy care plan.

The Keeping My Chest Healthy digital hub launched in September 2023. The development of the digital hub has followed on from the respiratory pathway and screening work that has been done by BDCT's learning disability health support team.

Neurodiversity

Neurodiversity describes a term of understanding that people think and feel, experience, and interact differently with the world; that these differences are normal and to be expected, celebrated, and not treated as deficits.

Autism, attention deficit disorder (ADHD), dyslexia and dyspraxia are examples of neurodevelopmental conditions. They are 'spectrum' conditions, which means they come with a wide range of characteristics of how people learn and process the world around them. Autism and other neurodevelopmental conditions are diagnosed by a trained professional and while only a minority of the population will meet the diagnostic criteria, a larger proportion will share neurodivergent traits and require support.

The evidence is clear: with early identification and appropriate adaptations and support, the majority of neurodivergent people can live happy and productive lives, achieving well in mainstream schools, finding rewarding employment and making significant contributions to arts, culture, civic society, and community. The benefits to individuals and wider society are clear.

It is equally clear that without the right support, and especially where they are growing up and living in poverty, neurodivergent people face significantly greater risks: of educational failure, poor mental and physical health, unemployment, exposure to criminality and other harms. This is the reality for an increasing number of our neurodivergent children and adults; the costs to individuals and wider society are increasing and unaffordable.

What we will do

We will implement a strategy of change and improvement in line with the national strategy for autistic children, young people and adults.

Promote better lives

We want Bradford District and Craven to become a neurodiverse friendly district. We need to improve understanding of neurodiversity among the general population as well as those working with neurodiverse individuals. Being ‘neurodiverse friendly’ means adapting and creating inclusive environments, places, policy and services in which everyone can thrive – both people with diagnosable neurodivergent conditions and those with neurodivergent traits

Develop resources – we need to build capacity across the district, to adapt environments. This includes making resources available, where needed. We will use the opportunities that the UK City of Culture Bradford 2025 brings to accelerate this ambition.

Respect rights

People who are neurodiverse have the right to the same opportunities as anyone else and should be treated with dignity and respect.

Coproduction – our core ethos is enabling and involving neurodivergent people, their families, and their carers to not only have their voices heard on what they think is important but to give them the power to make the changes they want to see.

Reducing inequalities – is a specific focus, but also features intrinsically across the other programme areas. We want to develop a better understanding of the inequalities neurodiverse people face and improve people’s health outcomes. New research by the Centre for Applied Education Research provides valuable insights on the way characteristics like gender, ethnicity and poverty affect everything from attitudes to autism and the time taken to access diagnostic services.

Employment – being employed is a protective factor for most people and neurodivergent people are no different. Every person has a right to be included in the workplace but often employers lack the knowledge, confidence, capacity or skills to adjust workplace and job roles. We will develop confidence in employers to develop inclusive practices to uphold people’s rights but also recognise the value neurodivergent people bring to the organisation, the economy, and their own quality of life.

Improve support

Building the right support – the evidence shows that neurodivergent children and adults face greater risks of mental ill health, particularly if they have not received the support they need, early enough, or where they have also faced other adversities (poverty, poor education, poor housing etc). We will improve the support we provide neurodivergent people so they can live healthy, safe, and ordinary lives, that include relationships, education, training, employment and access to good healthcare.

Mental health and physical health – we know that we need to address the physical and mental health inequalities that exist for neurodivergent people. Neurodiversity is not a mental health condition, but often, due to a lack of recognition of their neurodivergent traits and because of inappropriate support, many children and adults on the neurodivergent spectrum experience mental ill health. They also are more likely to have physical health conditions investigated much later than people who are neurotypical and this impacts on the quality and length of healthy years lived. We will develop and increase the range of appropriate community support to prevent neurodivergent people reaching crisis and having unnecessary hospital admissions.

Preparation for adulthood – we want every young neurodivergent person to have a clear pathway for transition from being a child to being an adult which is developed at the right time for the person and includes access to a range of suitable timely support. We will improve transitions into adulthood through earlier discussion, planning, information and advice and guidance.

Workforce – neurodivergent people have different skills to bring to the workplace and with the right support, they make a valuable contribution in the work environment. The diversity of abilities is an asset to be celebrated in the workplace. We will develop confidence in employers to develop inclusive recruitment approaches and recognise the value and benefits that neurodivergent people bring to the economy, and improve their own mental wellbeing and quality of life.

Increased access and diagnostic capacity – assessments are important but not all people with neurodivergent characteristics meet the diagnostic threshold; those who do often find their diagnosis offers no guarantee of the right support. We will use our framework to establish a needs-led system: one that gives practitioners the resources, skills and tools to build the right support earlier, and respond to needs faster, whether they are referred for assessment or not. We will ensure people who do require a neuro-assessment can get one, in line with statutory timelines. We will increase our diagnostic capacity to reduce and sustain reductions in waiting times for assessments.

What will be different

- Bradford District and Craven to become a neurodiverse friendly district.
- More people are accessing support in a timely way within their local communities to live independently.
- There will be a wider range of support and accommodation options for people with autism and sensory impairments.
- Increase the number of people recruited to and retaining meaningful employment.

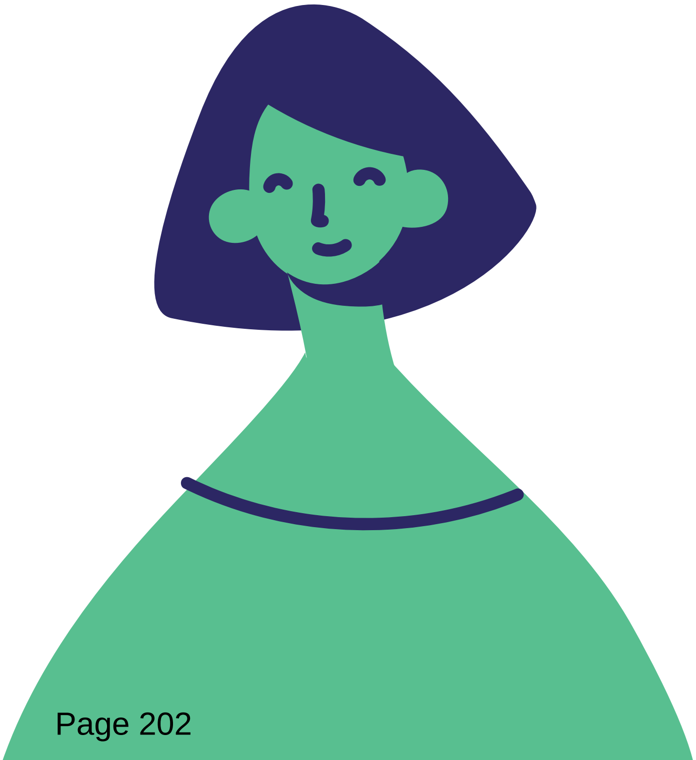
Spotlight: Evidence-led approaches to early identification and support

The ‘SUCCESS’ trial: Born in Bradford research has shown a strong link between the scores children received within their Early Years Foundational Stage Profile (EYFSP), SEND and autism diagnosis.

Bradford’s Education Opportunity Area worked with local schools, representatives from the Department of Health and Social Care, public health and Bradford District Care NHS Foundation Trust to test ‘SUCCESS’. This approach combines tools to help teachers identify children who may benefit from further diagnostic assessment with multidisciplinary team deployment into schools to carry out those assessments.

The trial demonstrated the ‘SUCCESS’ approach offered both efficiencies and wider benefits to all. This has been adopted successfully by other areas and is nationally recognised.

The **Electronic Developmental Support Tool** is a fast, easy to use, digital aid for teachers: to identify more accurately and meet more quickly children’s learning and support needs, without requiring support from specialist education or health professionals. It has been developed by the Centre for Applied Education Research and Bradford’s Education Psychology team. The EDST is not a diagnostic tool but draws on proven evidence. It is designed to be completed by teachers, with parents, and overseen by SENCOs, for all children, to help schools identify and meet needs at the earliest possible opportunity. The EDST is currently being trialled in 13 schools in Bradford. The trial is expected to expand to a further 50 schools, from January 2024, when it will include a Digital Advice Bank, automatically identifying recommendations for evidence-based support and interventions, appropriate to the needs identified through the tool.



Substance use

In line with the NHS Long Term Plan, we want to create a system where no one with substance use issues falls through the gaps in health and social care services. We will treat addiction as a chronic health condition, where people who need it can easily access support and treatment. We will address system gaps by introducing effective pathways and better integration.

The Alcohol and Drugs Strategic Group, accountable to the Combating Drugs Partnership, is working with local and national partners to deliver the strategic priorities of the national 10-year drug strategy ‘From harm to hope’. There is a particular focus currently on the priority to ‘improve treatment and recovery systems’ by breaking supply chains and achieve a generational shift in the demand for drugs.

Promote better lives

We want to create a system where everyone with a substance use issue has access to opportunities to live life to their potential.

Respect rights

We want to create a system where no one with substance use issues falls through the gaps.

Improve support

We will treat addiction as a chronic health condition, where people who need it can easily access support and treatment.

We will address system gaps by introducing effective easy to access pathways and better integration.

What we will do

There will be two main principles guiding improvements to substance use access and treatment:

1. Everyone's job: a joint approach from drug and alcohol and mental health providers and commissioners is required to meet the needs of people with co-occurring conditions.
2. No wrong door: providers in mental health, drug and alcohol treatment and other providers should have an open door to people experiencing co-occurring conditions and treatment should be accessible through every contact point, making every contact count.

Our priorities for the Bradford District and Craven are:

Healthy communities

- Prevention starts early in life
- Criminal justice system: continuity of care between prison and community and enhanced partnership recovery activity.

Support to live well

- Early identification and wider health: screening, reducing stigma and engagement for all
- Support people to maintain stable tenancies.

Support to get well

- Support the recovery from treatments for drugs and/or alcohol use in the long-term
- Alcohol support: screening, early advice and a range of support packages
- Support when you need it – no wrong door for people with substance use issues accessing urgent and crisis support.

Delivery and accountability through local strategic and operational groups consisting of wider partners.

What will be different

- Easy access for people with substance use needs to get physical and mental health support
- Recovery: more people successfully recover from drugs and/or alcohol use in the long-term
- Reduce harm and the number of alcohol and drug related deaths
- Secure investment for services to deliver high quality recovery focussed care
- Work with housing providers and employers to enable better support, rehabilitation, and services for people with substance use needs

Spotlight – Integrated Outreach

The Integrated Outreach Team (IOT) support people with severe and enduring mental health issues, who have difficulty engaging in mainstream services. The team have an established link with the substance use treatment provider, New Vision Bradford (NVB) who manage people with substance use and mental health issues.

The IOT coordinator has protected time with the Clinical Medical Lead at NVB, to access supervision and clinic time that is flexible for people who struggle to attend appointments. Good relationships, joint review meetings and community visits, means that both teams have an identified link person, who can offer advice or contact details from the wider community. This increases knowledge and support for both the IOT and NVB.

This partnership working has reduced waiting time for service users who need to be restarted on opiate substitute treatment therefore reducing the risk of overdose – and overall had a positive effect on reducing risk and improving care for people who would otherwise not be able to access mental health and /or substance use treatment.

System priorities: Working with our health and care partnership priorities

Our Bradford District and Craven Health and Care Partnership has identified five priorities, of which Healthy Minds is one. We will work in partnership with the other priorities to ensure the needs of people with mental health, learning disabilities, neurodiversity or substance use issues are paramount. We also want to play our part to support and deliver our shared objectives by understanding the specifics of each priority and maximise our resources by working effectively together.

The Healthy Communities priority is about engaging and empowering communities to enhance the things that keep people happy and healthy. Our approach is asset based, working with the skills, knowledge, and experience that strengthen trust, social networks and civic engagement. We want to do this in a way that inverts the power to act by shifting power and control away from services and professionals and giving a voice to those who are marginalised and seldom heard. The Healthy Communities priority forms the foundation of our work in Healthy Minds.

Our vision for our Access to Care priority is to ensure that our population can receive the care they need in the place that is the most appropriate to deliver it. We will achieve this by:

- improving access to health and care for the communities we serve;
- removing the barriers that create inequalities in accessing care; and
- ensuring our people receive the right care in the right place first time.

By working together, we aim to achieve the following for our communities:

- earlier diagnosis and treatment for people with major health conditions such as mental illness;
- improved health outcomes for people accessing pathways of care;
- people can access the care they require using their preferred method (digital/in person) at an appropriate time for their presenting need; and
- improved patient experience.

The Healthy Children and Families priority is led by a strong focus on working with children, young people and families and involving them as much as possible in designing our services. Our vision for our Healthy Children and Families priority is to ensure that people have the best start to life and that we can enable children to be ‘happy, healthy at home’. The work of Healthy Minds takes an all-age approach and where relevant and appropriate, we will work through the governance and partnership arrangements of this priority.

Our People Development priority: our services are not possible without the workforce who deliver them and we will support, invest and develop our people. The workforce programme has a focus on growing leadership, recruitment and retention, developing new ways of working and the wellbeing of our staff.

System enablers:
Working with our enabler programmes

Living Well is Bradford District's whole system approach to tackling growing levels of obesity and improving wellbeing. Our vision is to create a district where we are all making it easier for everyone to live a healthy and active lifestyle. We aim to enable the places and organisations in which we live, work, learn and play to promote health and wellbeing by making it easier for people of all ages to adopting healthier behaviours and become better able to care for themselves.

The **Reducing Inequalities Alliance** aims to inspire a shared vision for reducing inequalities in health (and the determinants of health). Building confidence and skills in our workforce to reduce inequalities: we want to make reducing inequalities part of everything we do as a workforce. We will support individuals and organisations to know how their work is helping to address inequalities. We are committed to reducing inequalities, and to achieve this we need to develop a clearer understanding of 'what works.' A key function of the Alliance is to create the time and space to share learning with our partners, so that we can do this together.

The **Digital, Data, Intelligence and Analysis:** enabling programme is to best support the needs of our population and the requirements of our colleagues through providing class leading enabling digital technology.

We also have an ambition to make the data that partner organisations hold work harder, to enable population health insights that will improve health outcomes, and by giving health and social care professionals all the information they need wherever they are working. Our **'Data as One'** work will continue to draw all the organisations in the partnership closer together, mitigating perceived administrative barriers for the VCS sector (e.g., supporting information governance accreditation) and establishing closer working with the local authorities.

Research and innovation: We have a strong ethos and track record of healthcare research collaboration within the Bradford District and Craven area which has been in existence for many years. This enabler supports the development, delivery and dissemination of research ideas including the development of people to create new research and deliver research studies that improve the mental health, learning disability and autism services we design and deliver.

Engagement: The services we deliver, directly impact the lives of people. We are therefore committed to ensuring that the work of our partnership is influenced by our population through conversations and engagement. Connecting, listening to, and having a consistent feedback loop with communities on an ongoing basis will also help us build trust. This is something that is being demonstrated through the partnership's 'Listen In' engagement work and through our 'Listening Rooms' project as part of our local equity, diversity and belonging programme. Our engagebdc.com website provides further information on opportunities for people to get involved and influence decision making locally from involvement exercises through to formal consultations on issues that matter to people.

Sustainability and social value

Our Healthy Minds Partnership Board is serious about sustainability and social value and takes a broad view on what these mean it's not only volunteering opportunities, carbon counting, climate and environmental issues. We see issues of social justice, equity and sustainability of the workforce as firmly within the remit of sustainability and social value. The social value we generate is at the heart of what we do through our work across our services. Our approach to promoting better lives, respecting rights and improving services has social value at its core.

The most sustainable workforce is one that feels supported and fulfilled by their work and working conditions. Optimising peoples' mental health is by far the most sustainable thing we can do. Our place-based partnership works together to support staff but also reduce carbon footprint by demonstrating shared building use and reducing the travel for staff, members and carers. Our approach to working with our providers and partners, and more increasingly with wider business partners, is to maximise the social value implicit in having a happy, healthy and supported workforce.

There is a strong link between the impact of climate change on mental health, the evidence base regarding the benefits of nature for mental wellbeing continues to grow and as a place-based partnership, we are keen to promote and encourage this and so we will embrace: nature in our service framework. This involves incorporating green spaces into workplaces; facilitating people to develop their own relationship with nature or engaging with the natural world within our communities.

Volunteering for Healthy Minds

Volunteers are a valuable part of the workforce across health and care providers, enhancing core services and delivering essential support to people across the district.

Whilst organisations benefit from the time, skills, knowledge and experience volunteers bring to every organisation and people they work with, the act of volunteering within itself can be a significant contributor to wellness and support the culture around how organisations consider and make services more accessible.

Volunteering for Better Lives

We recognise that volunteers benefit from delivering meaningful activity and the feelings of validation and gratitude can have a positive impact on the volunteer's health and wellbeing. Layered on top of this are impacts such as developing skills and confidence, routine, giving back for care received, reduced loneliness and isolation all continue to build the impact of volunteering for an individual.

We have introduced a Healthy Minds volunteering co-ordinator role to enhance how we promote better lives, respect rights and improve support through broadening our workforce, and creating volunteer to career pathways.

Promote better lives

Volunteering provides a well evidenced pathway to employment, moving people who do not believe they could work towards the belief that they can. People who are unable or not ready to work due to their mental health can build skills, confidence, validation and self-belief through the routine and responsibility of volunteering.

Aneekah has volunteered with Bradford District Care NHS Foundation Trust since 2017, having been introduced to volunteering via Young Dynamos, a young person's involvement group. She says, "I'm now in my second year of university, the vice executive of the Psychology Society, and recently completed an internship. All the volunteering I did has led up to this. Volunteering has pushed me out of my comfort zone. I've learnt so many skills, and gained confidence doing so, subsequently improving my mental health. It taught me that, regardless of one's mental health, you can still make an impact."

Respect rights

Volunteering gives people with an opportunity to share their lived experience, expertise and understanding to recognise people's needs and rights to be heard and acted on.

David is a volunteer in the Four Seasons Café at Lynfield Mount, "I used to be a patient myself so I know what it's like. I like to listen to patients and support them. I also feel really good being able to give back to the hospital which gave so much to me."

Improve support

The activities and interventions delivered by volunteers can play a valuable role in supporting recovery and keeping people well through meaningful activity. It also provides hope for others who see people volunteering that they can relate too. Drawing on lived experience of individuals to support others in their recovery and wellness journeys.

Mike attends a Well Together singing group and has experienced the impact first hand of volunteer led activities. "I had never done any singing before" says Mike "however, that wasn't the point, as it's not about the singing [as such] it's about being with others and not being at home on your own." Mike's quality of life has improved immeasurably since his involvement with Well Together. He feels less stressed and believes that this is a direct benefit from his involvement in the singing, health and community groups. He says: "my self-esteem and confidence have also been boosted, enabling me to feel confident not only in joining groups but also in setting up groups myself."

Embedding volunteers as part of the Healthy Minds workforce is an exciting opportunity to develop a culture that has kindness, compassion and understanding where opportunities to improve prevention and recovery can be provided in more creative ways by people from our communities. We have invested in a Healthy Minds volunteer co-ordinator and their role will ensure the development of high quality, high impact and well supported volunteering opportunities across our services and within our communities.

Measuring our success

Bradford District and Craven Health and Care Partnership has developed its Joint Forward Plan:

- To provide a single view on how the partnership will operationalise its strategy.
- To provide clarity for the Partnership Board so it can hold our system to account for the measurement and delivery of our key transformational objectives.
- To enable NHS West Yorkshire Integrated Care Board (ICB) and NHS England to understand how our plans deliver the West Yorkshire Joint Forward Plan and Integrated Care Board Strategy.

A link to our local plan can be found on our partnership website[20].

Making a difference

The 11 statements developed in our priority ambitions are the measures of success defined by our communities. To be successful we must deliver each of them to a high quality, and in a way that makes a noticeable difference in people's lives.

To help us understand how we are doing, we will work with community groups and our partners to develop our measures and ensure we are delivering on the statutory and strategic commitments we have as a system partner in our health and care partnership.

We will also conduct a series of deep dives with our Reducing Inequalities Alliance to ensure we understand the data and our outcomes, developing actions that address variance and areas of improvement. Our first deep dive on Serious Mental Illness (SMI) and physical health checks has led to the development of a full cross agency action plan.

Promote better lives	1	**Creating opportunities:** "I am a person with abilities, possibilities and a future"
	2	**Needs led, not diagnosis led:** "I am not defined by my mental health diagnosis and the level of distress."
	3	**Promoting independence:** "I am supported through the stages of life where things can be difficult."
Respect rights	4	**Listening to people:** "My voice is heard and included"
	5	**Human rights:** "I am supported to maintain my rights and dignity and to make choices that enable me to live a healthier, happier life"
	6	**Working together:** "I am in control and actively involved in my care and support"
	7	**Respecting people:** "Ask for my consent. Share information appropriately, so I don't have to repeat myself."
Improve support	8	**High quality services:** "I have access to information, support and care that meets and my cultural choices"
	9	**Improving support:** "When I need help, I can access this quickly and easily and services approach me with kindness, compassion and understanding"
	10	**Working together:** "I will know the name of the person who coordinates my support"
	11	**Supporting carers:** "My family or carer who may support me, will be respected and actively involved in my care with access to information and support they need."

Table 1: Our outcomes as defined by people and carers

	How we measure success	Measure exists
Healthy communities	Life expectancy for people with mental health, learning disability, neurodiversity	Yes
	Healthy life expectancy for people with mental health, learning disability, neurodiversity	Yes
	Access to employment support such as Individual Placement Support (IPS)	Yes
	Working age adults in mental health, learning disability, neurodiversity services in paid employment	Yes
	People with mental health, learning disability, neurodiversity living in their own home	No
	Vaccinations for people with learning disabilities	Yes
	Physical health checks for people with serious mental illness Physical health checks for people with learning disabilities	Yes
	Carers satisfaction survey	Yes
	Access to other major physical health services, cancer, diabetes, cardiovascular and respiratory	Yes
	School readiness	Yes
	Access to prevention and early help support	No
Community support	Talking therapies access (previously known as IAPT)	Yes
	Talking therapies recovery	Yes
	Core community mental health service contacts	Yes
	Children/young people access to mental health and eating disorders services	Yes
	Prescribing rates for people with serious mental illness, learning disabilities, neurodiversity and substance use issues	Yes
	People receiving individual service funds or personal health budgets	No
	Carers receiving direct payments	No
	Access to support for people from ethnic and culturally diverse communities	Yes
Specialist support	Dementia diagnosis	Yes
	Autism diagnosis and waiting times	Yes
	Perinatal mental health access	Yes
	Adult and older adult discharge mental health	Yes
	Inpatient care for learning disabilities	Yes
	Alcohol specific hospital admissions	Yes
	Completion of alcohol treatment	Yes
	Completion of drug treatment	Yes
	Safeguarding measures	Yes
Urgent and emergency care	Unplanned admissions to mental health services within 30 days of an inpatient discharge	Yes
	Out of area placements	Yes
	A&E mental health attendance	Yes
	Mental health bed occupancy (length of stay)	Yes
	People who access mental health support via police or justice routes	

Table 2: Our measures

Conclusion

This strategy sets out the range of work that the mental health, substance use, learning disability and neurodiversity programme and the wider partnership will take forward in the next five years. During this time our work will continue to evolve, and we will over this period place greater emphasis on some areas than others depending on need, capacity and opportunity.

The Healthy Minds Partnership Board considers this a live document. It sets our stall out for the changes we want to see, and it informs our measures of success. But we will continue to revisit our commitments, to check our progress and change our workplans accordingly.

We also know that five years is a long time in the NHS and local government. National policy and the political landscape will shift significantly over this time and may well have an impact on our ambitions and the plans of work. We will review, at least annually, whether the strategy still holds true, reporting any significant variance to the programme board.

Finally, we hope that this strategy will support our staff and partners to work together to do this and improve the experience of people, their carers and their families accessing our services. It is deliberately ambitious in a world where NHS funding is compromised and where mental health, learning disability, neurodiversity and substance use services have been underinvested in for years.

Our Bradford District and Craven Health and Care Partnership is built on our ethos of 'Act as One', through this ethos we can realise our ambition of people living 'happy, healthy at home'.

Our partnership is what makes this strategy possible and together, we can deliver for the communities we serve.

Thank you.

Healthy Minds Leadership Team

Notes on this strategy

Please note, this strategy is a live document and we invite continued feedback and input via **wellbeing@bradford.nhs.uk.** Please put Healthy Minds Strategy in the subject line.

How we developed this strategy

This strategy has been developed by a task group set up by the Healthy Minds Partnership Board. Members of this group supported a wide scale district wide series of surveys and focus groups that culminated in a report titled “Accessibility of Mental Health Services in Bradford District and Craven”, and through a series of subsequent events and workshops across the district.

About our Healthy Minds Partnership

Our Healthy Minds Partnership, that forms one of the five priorities for the Bradford District and Craven Health and Care Partnership, is made up of all the health and care organisations that support local people. We recognise that each organisation will have their own commitments and duties to fulfil but together, we can deliver on the ambition for our place. The Partnership purpose is clear, to add value by working together. We do this by:

1. Understanding the needs of and the inequalities faced by our population as well as the strengths and assets in our communities.
2. Setting strategy, outcomes, objectives and priorities and aligning resources, e.g., Mental Health Investment Standard, Service Development Funds and the joint commissioning plan[21]
3. Overseeing the development and delivery of the integrated programmes of work that the Healthy Minds Partnership is responsible for (see figure 4 above). In our oversight, we will ensure we are:
    - Delivering our work in line with our statutory duties and commitments
    - Applying innovation, best practice and embedding a prevention and life-course approach to transform the support and care we deliver
    - Supporting our workforce
4. Identifying and enabling shared risk and governance as system partners.
5. Creating a sustainable and quality provider collaborative that promotes integrated working and delivery.

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Contacting us

Our Bradford District and Craven Health and Care Partnership

Information about the Partership our Bradford District and Craven Health and Care Partnership and work can be found at:
https://bdcpartnership.co.uk/healthy-minds/

How can you get involved or get in touch with us

If you would like to get involved in our Healthy Minds programmes of work, please get in touch with us by email at **wellbeing@bradford.nhs.uk.** We have a range of opportunities including volunteering, peer support roles, involvement roles, engagement and workforce vacancies.

Alternative formats

An Easy Read version of this document is available.
For copies of this strategy in alternative formats or further details, please get in touch with us at the email address: **wellbeing@bradford.nhs.uk**

Support

We also have a range of tools and resources hosted at www.healthyminds.services including a 'Support finder'.

Social Media

You can engage with us via social media through the following accounts:

@healthymindsBDC and **@ActasOneBDC**

@healthyminds.bdc and **@bradfordcravenhcp**

You can also find us on Facebook – Search for **Healthy Minds** or **Bradford District and Craven Health and Care Partnership**.

References

1 Bradford District and Craven Health and Care Partnership Strategy

2 Health inequalities are the avoidable, unfair and systematic differences in health between different groups of people

3 Act as One https://bdcpartnership.co.uk/about-us/#about-us-sections

4 A Partnership for Mental Health, Learning Disability and Neurodiversity operating under the Health and Care Partnership for Bradford District and Craven and brings together statutory and community health and care partners.

5 NHS Long-Term Plan https://www.longtermplan.nhs.uk

6 Integrated Care Systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. - You can find out about the West Yorkshire ICS here and the Bradford District and Craven Health and Care Partnership here.

7 A review of the mental health needs of ethnic and culturally diverse communities across Bradford District conducted by the Centre for Mental Health and to be published in October 2023. A copy of this can be found by going to this page.

8 West Yorkshire Integrated Care Board LeDeR - Learning from Lives and Deaths of People with a learning disability and autistic people Annual Report 2022/23

9 Source: National Autism Strategy (www.gov.uk)

10 Data source: Office of National Statistics 2016-2020 and NHS England 2019.

11 World Health Organisation

12 Young In Covid by the Khidmat Centres

13 Rapid Needs Review by Public Health

14 i-Thrive – http://implementingthrive.org

15 Community mental health framework

16 The Care Programme Approach (CPA) is a package of care for people with mental health problems

17 Copies of the Centre for Mental Health report on Children and Young People's Mental Health in Bradford District and Craven can be accessed by emailing **wellbeing@bradford.nhs.uk**

18 Learning Disability Mortality Review (LeDeR) report into the avoidable deaths of people with learning disabilities

19 Building the right support for people with a learning disability and autistic people (www.gov.uk)

20 Joint Forward Plan

21 A copy of our Joint Commissioning Plan can be obtained from **wellbeing@bradford.nhs.uk**

Bradford District and Craven Health and Care Partnership

wellbeing@bradford.nhs.uk
Healthy Minds 2024

City of
BRADFORD
METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director Children's Services to the meeting of Children's Overview & Scrutiny Committee to be held on 13 March 2024

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Subject:

Educational Standards – Early Years to Key Stage 4

Summary statement:

This report provides an update on the outcomes from national assessments for primary and secondary pupils for the academic year 2022/23 and updated information on the outcomes of Ofsted inspections within education settings.

EQUALITY & DIVERSITY:

Data is collected and presented here for Key Stage 2 and Key Stage 4 for groups including gender, English as an additional language, disadvantage and SEND. Data for children in care is collected and reported separately.

Marium Haque Strategic Director Children's Services	**Portfolio:** Children & Families
Report Contact: Richard Crane Phone: (01274) 432009 E-mail: Richard.Crane@bradford.gov.uk	**Overview & Scrutiny Area:** Children's Services

1. SUMMARY

1.1 This report provides an update on the outcomes from national assessments for primary and secondary pupils for the academic year 2022/23.

1.2 The report also provides members with updated information on the outcomes of Ofsted inspections in education settings.

2. BACKGROUND

2.1 For Early Years Foundation Stage Profile

- These statistics report on teacher assessments of children's development at the end of the early years foundation stage (EYFS), specifically the end of the academic year in which a child turns 5. This is typically the summer term of reception year. The assessment framework, or EYFS Profile, consists of 17 early learning goals (ELGs) across 7 areas of learning.

- This is the second publication since the 2020/21 EYFS reforms were introduced in September 2021. As part of those reforms, the EYFS profile was significantly revised. **It is therefore not possible to directly compare 2021/22 and 2022/23 assessment outcomes with earlier years.** Additionally, the 2019/20 and 2020/21 data collections were cancelled due to coronavirus (COVID-19).

- The key EYFSP measure is called a 'Good Level of Development' (GLD). This includes Personal, Social and Emotional Development, Communication and Language, Mathematics, Physical Development and Literacy. Children are teacher assessed in each aspect and are judged against national standards as to whether they are 'emerging' (working below the standard), 'expected' (working at the standard) or 'exceeding' (working above the standard). Teacher assessments are moderated.

2.2 For Key Stage 2

- The Y6 cohort in 2022/23 experienced disruption to their learning during the pandemic, particularly at the end of year 3 and in year 4.

- These statistics have been updated with revised data published by the Department for Education on 14th December 2023.

- Pupils who meet the expected standard in reading, writing and maths (combined) are those who meet the expected standard in all three subjects. The expected standard in writing is a teacher assessment of 'working at the expected standard' (EXS) or 'working at greater depth' (GDS).

2.3 For Key Stage 4

- In 2020 and 2021, alternative processes were set up to award grades (centre assessment grades, known as CAGs, and teacher assessed grades, known as TAGs). As part of the transition back to the summer exam series adaptations were made to the exams (including advance information) and the approach to grading for 2022 exams broadly reflected a midpoint between results in 2019 and 2021. The approach to grading for the 2023 set of examinations was to move boundaries back more towards those of 2019.

- Given the unprecedented change in the way GCSE results were awarded in the summers of 2020 and 2021, as well as the changes to grade boundaries and methods of assessment for 2021/22, readers need to exercise caution when considering comparisons over time, as they may not reflect changes in pupil performance alone.

- Comparisons are made for each year from 2019 to 2021, because although results were published throughout the pandemic, it is more meaningful to compare the current outcomes to the last year summer exams were sat.

- These statistics have been updated with revised data published by the Department for Education on 1st February 2024.

3. OTHER CONSIDERATIONS

3.1 Early Years Foundation Stage Profile

		2019	2022	2023
Percentage of children receiving a Good Level of Development	**Bradford**	68%	62%	62%
	Statistical Neighbours	68%	62%	64%
	National	72%	65%	67%
	Gap to National	-3.8%	-2.9%	-5.0%
Average number of Early Learning Goals at expected level per child	**Bradford**		13.4	13.3
	Statistical Neighbours		13.4	13.5
	National		14.1	14.1
	Gap to National		-0.7	-0.8

- 62.2% of children achieved a Good Level of Development (GLD) in Bradford in 2023, a slight decrease from 62.3% in 2022, and a further decrease from 68% achieved in 2019. The decrease between 2019 and 2022 was also seen nationally and across statistical neighbours. 2023 saw an increase in those children achieving a GLD both across statistical neighbours, and nationally, resulting in the gap to national widening.

- Prior to the 2020/21 EYFS reforms, the DfE published a further measure which was the mean average points score for children across all seventeen Early Learning Goals. In 2022, this was replaced with a measure which looks at the mean number of Early Learning Goals (ELG) children were at the expected level for. The maximum number would be 17, if every child was at the expected level for every early learning goal. In 2023, the average number of ELG at expected level for children in Bradford is 13.3, a 0.1 decrease compared to 2022. Statistical neighbours saw an increase from 13.4 in 2022 to 13.5 in 2023 and the national score remained the same as 2022 at 14.1. Subsequently, the gap to national has widened slightly.

3.2 Key Stage 2

		2019	2022	2023
Reading Test	**Bradford**	71%	72%	70%
	Statistical Neighbours	70%	72%	71%
	National	74%	75%	73%
	Gap to National	-3	-3	-3
Maths Test	**Bradford**	78%	70%	72%
	Statistical Neighbours	77%	70%	72%
	National	79%	72%	73%
	Gap to National	-1	-2	-1
GPS Test	**Bradford**	78%	69%	71%
	Statistical Neighbours	78%	71%	72%
	National	79%	73%	73%
	Gap to National	-1	-4	-2
Writing TA	**Bradford**	77%	68%	71%
	Statistical Neighbours	76%	67%	70%
	National	79%	70%	72%
	Gap to National	-2	-2	-1%
RWM Combined	**Bradford**	63%	57%	57%
	Statistical Neighbours	62%	56%	58%
	National	65%	59%	60%
	Gap to National	-2	-2	-3

- Outcomes in reading have decreased slightly in 2023 when compared to 2022, and prior to the pandemic. A decrease was seen across statistical neighbours and nationally resulting in the gap to national remaining static.

- In mathematics, although outcomes declined in 2022 when compared to 2019, 2023 sees an increase and the gap to national has narrowed.

- Grammar, punctuation and spelling outcomes have improved in 2023 after a decline in 2022. Statistical neighbours also saw an improvement, but the gap between Bradford and National has narrowed due to national outcomes remaining the same.

- Writing outcomes have improved in 2023 and the gap between Bradford and national averages has decreased.

- The outcomes for reading/writing/maths combined remained static in Bradford whereas there was a slight improvement across statistical neighbours, and nationally. This means that the gap between Bradford and national averages has increased.

3.3 **Key Stage 4**

		2021	2022	2023
Attainment 8	**Bradford**	45.90	43.80	41.00
	Statistical Neighbours	47.95	46.09	43.80
	National	50.90	48.90	46.40
	Gap to National	-5.00	-5.10	-5.40
Ebacc APS	**Bradford**	3.96	3.75	3.48
	Statistical Neighbours	4.12	3.97	3.77
	National	4.45	4.28	4.07
	Gap to National	-0.49	-0.53	-0.59
Basics 9-4	**Bradford**	63%	60%	55%
	Statistical Neighbours	67%	64%	60%
	National	72%	69%	65%
	Gap to National	-9	-9	-10
Basics 9-5	**Bradford**	43%	41%	36%
	Statistical Neighbours	46%	45%	40%
	National	52%	50%	46%
	Gap to National	-9	-9	-10

- The above table shows that attainment outcomes at Key Stage 4 continue to decline following the pandemic. Bradford outcomes remain lower than the statistical neighbour average, and the national average. The gap between Bradford and national has increased in all measures.

3.4 **Groups** (See Appendix 1, 2 & 3)

3.4.1 Early Years Foundation Stage Profile

- In 2023, 69.3% of girls in Bradford achieved GLD compared with 55.4% of boys in comparison to 74.2% of girls and 60.6% of boys nationally.

- Girls outperform boys when achieving GLD, both within Bradford and nationally. The gap between the performance of girls and boys in Bradford narrowed from 15% in 2022 to 13.9 % in 2023. The national gender performance gap widened from 13.2% to 13.6% during the same period.

- The gap between the average number of ELGs achieved at the expected level for girls and boys is slightly wider in Bradford at 1.8 compared to 1.5 nationally. In Bradford, girls averaged 14.2 ELGs and boys 12.4, whereas nationally girls averaged 14.9 and boys 13.4.

- The percentage of pupils eligible for free school meals in Bradford who achieved a GLD reduced in 2023. An increase nationally means that Bradford now performs below the national average.

- The average number of ELGs achieved at the expected level for children eligible for free school meals reduced by 0.6 in Bradford in 2023, compared to a 0.1 increase seen nationally. This has increased the gap between Bradford and

National.

- Bradford pupils from a Black ethnicity background performed better than other ethnic groups in the GLD measure during 2022 (68.7%) and 2023 (69.1%), though the gap to national has narrowed from 8.1% to 6.3% for this group. They also perform above both the Bradford and National overall average. When looking at the average number ELGs achieved, Bradford performed below the national average for all ethnic groups except pupils from a Black ethnicity background who averaged 13.7 ELG against a whole Bradford cohort of 13.3.

- Summer born children in Bradford perform below their counterparts nationally in the GLD measure, with a widening gap of 5.1% in 2023. Summer born children achieved the expected level for on average 1.2 ELGs less than their non summer born counterparts in Bradford (the gap nationally is 1.3).

- In 2023 19.4% of pupils receiving SEN Support in Bradford achieved GLD compared to 24.3% nationally, and the gap to national widened by 2%. SEN Support pupils in Bradford, on average achieved the expected level for 7 ELGs, which is 1.4 ELGs less than the national average for this cohort. The gap to national widened marginally from 1.3 in 2022.

3.4.2 **Key Stage 2 – Expected level for Reading, Writing and Maths Combined**

- Girls continue to outperform boys both within Bradford, and nationally. The Bradford gap between boys and girls is the same as seen nationally, with both groups achieving 2% below the national average.

- Disadvantaged pupils within Bradford perform better than their national counterparts in this measure, consistently achieving 1% more than disadvantaged children nationally over the last 3 years.

- Pupils from an Asian background are more likely to achieve in this measure than any other ethnicity group. This trend as seen nationally, though the Bradford gap to national for this ethnicity group is larger than seen across the other groups (7% below national compared to 3% below for White and Mixed ethnic groups).

- SEN support pupils within Bradford perform at a similar level to their national counterparts, with a very small gap between performance nationally (numbers are subject to rounding).

3.4.3 **Key Stage 4**

- Girls continue to outperform boys. At attainment 8 girls' achievement is 5% higher than boys and this is higher than the national gap. For attainment 9-4 and 9-5, the gap in performance between boys and girls is not as wide as the gap seen nationally.

- The gap in performance between Bradford pupils with an EHCP and those nationally is narrowing across all of the Key Stage 4 measures. Attainment 8 scores for pupils with SEN Support in Bradford improved when compared to nationally, but the gap in performance for attainment 9-4 widened and remained static for 9-5.

- The gap between disadvantaged and non-disadvantaged pupils is 13% for attainment 8. This is 2% lower than the national average. At Basics 9-4 and Basics 9-5, the difference between disadvantaged and other pupils is also lower in Bradford than the national average.

- Pupils whose first language is English outperform pupils whose language is not English by 2% in Attainment 8. Nationally, those pupils whose language is not English outperform pupils whose first language is English by 4%. At Basics 9-4 and Basics 9-5, the picture is similar with pupils whose first language is English outperforming pupils whose language is not English by 4% and 2% respectively. The national average picture is that those pupils whose language is not English outperform pupils whose first language is English by 3% and 5% respectively.

3.5 Ofsted Inspection Outcomes

	School Phase						
Ofsted Rating	Nursery	Primary	Secondary	All-through	Not applicable	16 plus	Grand Total
Good	3	107	12	2	7	0	131
Inadequate	0	0	0	0	1	0	1
Outstanding	4	11	7	0	3	2	27
Requires improvement	0	13	1	2	1	0	17
Serious Weaknesses	0	0	3	0	0	0	3
Special Measures	0	0	1	0	0	0	1
Grand Total	7	131	24	4	12	2	180

3.6 Local Authority Strategies to Support Improving Outcomes

- Raising Achievement Strategy funding has now finished but the Maths and English Hubs are continuing the work done around this for primaries – see Appendix 4.

- The Launchpad for Literacy initiative is proving to be very popular in schools and a presentation is provided at Appendix 6. This is a summary of the strategy.

- The Local Authority leads on KS2 assessment and moderation training which both Local Authority and Academy schools utilise.

- The Local Authority also provides schools with reading training opportunities.

- The Education Improvement Board has a KS4 and KS2 focus, looking specifically at outcomes for Year 11 and Year 6 – see Appendix 5.

- The Bradford Priority Investment Area Board also focuses on education outcomes across all key stages.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 There are no financial issues arising from this report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The Education Improvement Board has been newly established to oversee and drive the improvement agenda forward with a specific focus on attainment and absence.

6. LEGAL APPRAISAL

There are no legal issues arising from this report.

7. OTHER IMPLICATIONS

7.1 SUSTAINABILITY IMPLICATIONS

Not applicable.

7.2 TACKLING THE CLIMATE EMERGENCY IMPLICATIONS

Not applicable.

7.3 COMMUNITY SAFETY IMPLICATIONS

Not applicable.

7.4 HUMAN RIGHTS ACT

Not applicable.

7.5 TRADE UNION

Not applicable.

7.6 WARD IMPLICATIONS

Not applicable.

7.7 AREA COMMITTEE LOCALITY PLAN IMPLICATIONS

Not applicable.

7.8 IMPLICATIONS FOR CHILDREN AND YOUNG PEOPLE

Impacts on all children and young people. Outcomes for children in care will be reported separately to the Corporate Parenting Panel.

7.9 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

Not applicable.

8. NOT FOR PUBLICATION DOCUMENTS

8.1 Not applicable.

9. OPTIONS

9.1 Not applicable.

10. RECOMMENDATIONS

10.1 Committee members are asked to note the contents of this report.

11. APPENDICES

11.1 Appendix 1: Data for Early Years Foundation Stage Profile Groups

11.1 Appendix 2: Data for Key Stage 2 Groups.

11.2 Appendix 3: Data for Key Stage 4 Groups.

11.3 Appendix 4: Raising Attainment Strategy – Summary and Statement of Impact.

11.4 Appendix 5: Education Improvement Board Project Plan**.**

11.5 Appendix 6: Communication and Language, the Key to Children Succeeding.

12. BACKGROUND DOCUMENTS

12.1 Not applicable.

Appendix 1

Early Years Foundation Stage Profile Groups

Pupils achieving a Good Level of Development

		2019	2022	2023	Rate of Improvement
Good Level of Development All Pupils	**Bradford**	68.0%	62.3%	62.2%	
	National	71.8%	65.2%	67.2%	
	Gap	-3.8	-2.9	-5	
Gender					
Male	**Bradford**	61.4%	54.8%	55.4%	
	National	65.5%	58.7%	60.6%	
	Gap	-4.1	-3.9	-5.2	
Female	**Bradford**	74.8%	69.8%	69.3%	
	National	78.4%	71.9%	74.2%	
	Gap	-3.6	-2.1	-4.9	
Gap between Male/Female Performance	**Bradford**	13.4%	15.0%	13.9%	
	National	12.9%	13.2%	13.6%	
	Gap	0.5	1.8	0.3	
Free School Meal Eligibility					
Known to be eligible for Free School Meals	**Bradford**	55.0%	51.0%	47.9%	
	National	57.0%	49.1%	51.6%	
	Gap	-2	1.9	-3.7	
Not known to be eligible for Free School Meals	**Bradford**	70.0%	65.1%	66.7%	
	National	74.0%	68.8%	71.5%	
	Gap	-4	-3.7	-4.8	
Ethnicity					
Asian	**Bradford**	68.0%	61.2%	61.5%	
	National	71.0%	64.9%	66.7%	
	Gap	-3	-3.7	-5.2	
White	**Bradford**	69.0%	64.4%	64.2%	
	National	73.0%	66.3%	68.6%	
	Gap	-4	-1.9	-4.4	
Mixed	**Bradford**	69.0%	60.5%	62.4%	
	National	73.0%	67.0%	68.7%	
	Gap	-4	-6.5	-6.3	
Black	**Bradford**	62.0%	68.7%	69.1%	
	National	69.0%	60.6%	62.8%	
	Gap	-7	8.1	6.3	
Term of Birth					
Summer Born	**Bradford**		52.3%	54.3%	
	National		55.7%	59.4%	
	Gap		-3.4	-5.1	
Not Summer Born	**Bradford**		67.5%	67.9%	
	National		70.0%	72.8%	
	Gap		-2.5	-4.9	
SEN Status					
SEN Support	**Bradford**	34.0%	20.0%	19.4%	
	National	29.0%	22.9%	24.3%	
	Gap	5	-2.9	-4.9	
SEN - EHCP	**Bradford**	4.0%	3.1%	4.1%	
	National	5.0%	3.6%	3.8%	
	Gap	-1.0	-0.5	0.3	

Average number of Early Learning Goals at expected level per child

		2022	2023	Rate of Improvement
Average Number of Early Learning Goals at Expected Level per child All Pupils	**Bradford**	13.4	13.3	╲
	National	14.1	14.1	─
	Gap	-0.7	-0.8	╲
Gender				
Male	**Bradford**	12.5	12.4	╲
	National	13.3	13.4	╱
	Gap	-0.8	-1	╲
Female	**Bradford**	14.3	14.2	╲
	National	14.8	14.9	╱
	Gap	-0.5	-0.7	╲
Gap between Male/Female Performance	**Bradford**	1.8	1.8	╲
	National	1.5	1.5	─
	Gap	0.3	0.3	╲
Free School Meal Eligibility				
Known to be eligible for Free School Meals	**Bradford**	12.2	11.6	╲
	National	12.3	12.4	╱
	Gap	-0.1	-0.8	╲
Not known to be eligible for Free School Meals	**Bradford**	13.7	13.8	╱
	National	14.4	14.6	╱
	Gap	-0.7	-0.8	╲
Ethnicity				
Asian	**Bradford**	13	13.1	╱
	National	13.5	13.6	╱
	Gap	-0.5	-0.5	─
White	**Bradford**	13.9	13.7	╲
	National	14.3	14.4	╱
	Gap	-0.4	-0.7	╲
Mixed	**Bradford**	13.4	13.3	╲
	National	14.2	14.3	╱
	Gap	-0.8	-1	╲
Black	**Bradford**	13	13.7	╱
	National	13.1	13.2	╱
	Gap	-0.1	0.5	╱
Term of Birth				
Summer Born	**Bradford**	12.4	12.6	╱
	National	13.2	13.4	╱
	Gap	-0.8	-0.8	╲
Not Summer Born	**Bradford**	13.9	13.8	╲
	National	14.5	14.7	╱
	Gap	-0.6	-0.9	╲
SEN Status				
SEN Support	**Bradford**	7	7	─
	National	8.3	8.4	╱
	Gap	-1.3	-1.4	╲
SEN - EHCP	**Bradford**	1.9	1.9	─
	National	2.4	2.3	╲
	Gap	-0.5	-0.4	╱

Appendix 2

Key Stage 2 Groups – Revised

Pupils achieving expected levels for Reading, Writing and Maths Combined

		2019	2022	2023	Rate of Improvement
RWM Combined All Pupils	**Bradford**	63%	57%	57%	
	National	65%	59%	60%	
	Gap	-2	-2	-2	
Gender					
Male	**Bradford**	58%	54%	54%	
	National	60%	55%	56%	
	Gap	-2	-1	-2	
Female	**Bradford**	68%	61%	61%	
	National	70%	63%	63%	
	Gap	-2	-2	-2	
Disadvantaged Pupils					
Disadvantaged	**Bradford**	52%	44%	45%	
	National	51%	43%	44%	
	Gap	1	1	1	
Not Disadvantaged	**Bradford**	69%	64%	64%	
	National	71%	66%	66%	
	Gap	-2	-2	-2	
Ethnicity					
Asian	**Bradford**	66%	62%	60%	
	National	69%	66%	66%	
	Gap	-3	-4	-7	
White	**Bradford**	60%	53%	56%	
	National	64%	58%	59%	
	Gap	-5	-4	-3	
Mixed	**Bradford**	61%	53%	57%	
	National	66%	61%	62%	
	Gap	-6	-7	-5	
Black	**Bradford**	67%	60%	57%	
	National	64%	59%	60%	
	Gap	3	0	-3	
SEN Status					
SEN Support	**Bradford**	26%	21%	23%	
	National	25%	21%	24%	
	Gap	1	0	0	

Appendix 3

Key Stage 4 Groups – Revised

Average Attainment 8 Score

		2021	2022	2023	Rate of Improvement
Average Attainment 8 Score All Pupils	Bradford	46	44	41	
	National	51	49	46	
	Gap	-5	-5	-5	
Gender					
Male	Bradford	43.2	40.9	38.6	
	National	48.1	46.4	44.2	
	Gap	-4.9	-5.5	-5.6	
Female	Bradford	48.8	46.7	43.6	
	National	53.9	51.5	48.7	
	Gap	-5.1	-4.8	-5.1	
Disadvantaged Pupils					
Disadvantaged	Bradford	37.2	34.9	32.5	
	National	40.3	37.7	35.1	
	Gap	-3.1	-2.8	-2.6	
Not Disadvantaged	Bradford	50.3	48.4	45.7	
	National	54.7	52.9	50.4	
	Gap	-4.4	-4.5	-4.7	
Ethnicity					
Asian	Bradford	48.0	47.1	43.7	
	National	55.8	55.0	53.5	
	Gap	-7.8	-7.9	-9.8	
White	Bradford	44.5	41.2	38.5	
	National	50.2	47.9	45.2	
	Gap	-5.7	-6.8	-6.7	
Mixed	Bradford	43.4	39.4	35.8	
	National	51.3	49.5	46.9	
	Gap	-7.9	-10.2	-11.1	
Black	Bradford	47.0	42.1	45.1	
	National	50.0	48.9	46.8	
	Gap	-3.0	-6.8	-1.7	
English First Language					
English	Bradford	47.2	44.4	41.6	
	National	50.8	48.5	45.9	
	Gap	-3.6	-4.1	-4.3	
Other than English	Bradford	43.6	42.9	39.9	
	National	52.1	51.4	49.4	
	Gap	-8.5	-8.5	-9.5	
SEN Status					
EHCP	Bradford	12.8	10.4	12.6	
	National	15.7	14.3	14.0	
	Gap	-2.9	-3.9	-1.4	
SEN Support	Bradford	31.1	29.1	28.1	
	National	36.7	34.9	33.3	
	Gap	-5.6	-5.8	-5.2	

Percentage of pupils achieving Basics 9-4

		2021	2022	2023	Rate of Improvement
% Achieving Basics 9-4 All Pupils	Bradford	63	60	55	
	National	72	69	65	
	Gap	-9	-9	-10	
Gender					
Male	Bradford	60	57	53	
	National	69	66	63	
	Gap	-9	-10	-10	
Female	Bradford	67	63	57	
	National	75	72	68	
	Gap	-9	-9	-10	
Disadvantaged Pupils					
Disadvantaged	Bradford	47	44	38	
	National	53	49	44	
	Gap	-7	-5	-6	
Not Disadvantaged	Bradford	72	68	64	
	National	79	76	73	
	Gap	-7	-8	-9	
Ethnicity					
Asian	Bradford	67	66	60	
	National	78	78	76	
	Gap	-11	-12	-15	
White	Bradford	61	55	51	
	National	72	68	64	
	Gap	-11	-12	-13	
Mixed	Bradford	59	53	45	
	National	72	69	65	
	Gap	-12	-16	-20	
Black	Bradford	65	56	61	
	National	71	69	66	
	Gap	-6	-14	-5	
English First Language					
English	Bradford	66	61	56	
	National	73	69	65	
	Gap	-7	-7	-9	
Other than English	Bradford	59	58	52	
	National	72	72	68	
	Gap	-13	-14	-16	
SEN Status					
EHCP	Bradford	15	8	11	
	National	16	14	13	
	Gap	0	-5	-3	
SEN Support	Bradford	30	30	27	
	National	42	39	37	
	Gap	-13	-9	-10	

Percentage of pupils achieving Basics 9-5

		2021	2022	2023	Rate of Improvement
% Achieving Basics 9-5 All Pupils	Bradford	43	41	36	
	National	52	50	46	
	Gap	-9	-9	-10	
Gender					
Male	Bradford	39	38	34	
	National	48	47	43	
	Gap	-9	-9	-10	
Female	Bradford	47	45	38	
	National	56	53	48	
	Gap	-9	-8	-10	
Disadvantaged Pupils					
Disadvantaged	Bradford	28	26	22	
	National	32	30	25	
	Gap	-4	-3	-3	
Not Disadvantaged	Bradford	51	49	43	
	National	59	57	53	
	Gap	-9	-9	-9	
Ethnicity					
Asian	Bradford	47	46	40	
	National	61	62	59	
	Gap	-14	-16	-19	
White	Bradford	41	36	31	
	National	51	48	43	
	Gap	-10	-12	-12	
Mixed	Bradford	38	37	28	
	National	52	50	46	
	Gap	-14	-13	-18	
Black	Bradford	39	43	40	
	National	49	50	46	
	Gap	-10	-7	-5	
English First Language					
English	Bradford	45	42	36	
	National	52	49	45	
	Gap	-7	-7	-8	
Other than English	Bradford	39	40	34	
	National	53	54	50	
	Gap	-13	-15	-16	
SEN Status					
EHCP	Bradford	8	4	6	
	National	8	7	7	
	Gap	0	-3	-1	
SEN Support	Bradford	16	16	13	
	National	22	23	21	
	Gap	-6	-7	-7	

Appendix 4

Raising Attainment Strategy – Summary and Statement of Impact

Background	
This was a primary based project, aimed at the lowest performing schools across the district. The key objective was to support the development of leadership and teaching in maths and English, leading to sustained improvement in attainment at the end of each key stage.	
Actions	
English	• Support was procured from the English Hub at Burley Woodhead. • Using data from recent KS1 and KS2 results, potential schools were identified as ones which would benefit from support. • Once accepted onto the strategy, an initial audit was carried out to ascertain areas for improvement and an English SLE was allocated to work with the English subject lead in the selected school. • This equated to 8 Bradford schools. • SLE's organised visits based on need and capacity of schools. In some cases, this was weekly or fortnightly, in others once a half term. • A progress report was completed after each support session and shared with ND (RAS), the Headteacher and the English Lead.
Maths	• In a similar way, support was procured from the Maths Hub at Halifax. Key schools were identified, audited and allocated a maths SLE to work with the maths subject lead within the school. • This equated to 23 Bradford schools. • Maths SLE's visited schools on average, once a fortnight, completing progress reports after each visit. • From Jan 23, 7 of the lowest performing RAS schools took up the offer of face-to-face White Rose Maths tutoring. This consisted of twice weekly tutoring sessions for 9 Y6 six children (3 groups of 3) until the start of KS2 SATs. • At the same time, weekly boosters (aimed at Year 2 and 6) sessions were also offered and delivered weekly by the allocated SLE in individual schools.
Impact	
English	• Support in all 8 of the engaging schools has been positively received. • 2 of the schools were accepted by the English Hub as Wave 4 support schools and will continue to be supported with their SSP. • 5 of the schools receiving intensive support from the strategy have improving KS1 reading and writing results. • 5 schools have shown marked improvement in phonics. • 3 have improved scores in phonics, KS1 reading and KS1 writing.
Maths	• Through observation at the exit reviews, teacher confidence in all RAS schools was visibly improved. All maths middle leaders felt they

	were better armed to lead their subject and could confidently assess their school’s strengths and areas that needed further development (see exit audits) • Strong maths teaching across the school was identified by Ofsted in 3 schools who underwent inspection during their time with RAS. • 2023 data highlighted gains in many of the project schools: - 12 schools improved their KS1 maths results; - 12 schools improved their KS2 maths results; - 8 schools improved both their KS1 and KS2 results. • Of the 7 schools receiving WRM tutoring, all children increased their own confidence score from beginning to end of the tutoring programme and 92% of all tutored children made progress from their starting points. • All RAS schools now have stability in their leadership of the subject. The maths lead in each of the schools will continue to be the lead next year and is familiar with the expectations required by the Maths Hub. All schools have signed up to continue working with the Hub through a variety of DFE funded programmes – e.g. Teaching for Mastery, Sustaining or embedding programmes etc.
Future plans The focus over the last 18 months has been on improving outcomes at the end of both key stages. In order to future proof results in Bradford’s LA schools, that focus will now shift to Early Years with the emphasis on ‘keeping up’ rather than ‘catching up’.	
English	• In order to continue supporting Bradford LA schools, the ‘Launchpad to Literacy’ programme has been procured to support the Early Years phase. • This has been offered to all Bradford LA schools, was launched in July 23 and will be delivered over the next 2 academic years. The offer includes the Launchpad to Literacy toolkit, CPD days (mixture of face to face and virtual) and bespoke support every half term. • This will be overseen by the Early Years Officer at Bradford and overall impact will be judged at the close of the project summer 2025.
Maths	• The Maths Hub will continue to work with 6 identified schools, for the whole of the next academic year, with a clear focus on improving practice in the Early Years. • This will include an entry and exit audit, online subscription to the EYFS maths resources, 3 face to face CPD days, access the Maths Hub webinars and 6 bespoke SLE support days throughout the year. • This will be overseen by the EYFS Maths Hub lead and the Early Years Officer at Bradford and impact will be judged and reported at the exit audit in the summer term 2024.

Appendix 5

Education Improvement Board Project Plan

Focus – Improving Attainment Outcomes in 2024 for Y6 and Y11
Aim – To have maximum impact on attainment in key areas by working with schools with large cohorts

Actions	Timescale	Resources	RAG	Impact
Using IMT data identify target schools using criteria: - Large cohorts - ‘spiky’ profile	By end of autumn term 2023	IMT data	🟩	
Identify Support headteachers for primary schools 5 matches	End of January 2024		🟩	
Match school to support headteacher	End of January	Ensure backfill for headteachers – LLE rates LA schools from SIMG	🟩	
Plan support activity with headteachers to focus on - Identifying pupils on track for reaching expected standard in one subject but not the other - Work with school on purposeful tracking of Y6 - Work with subject leader and Y6 teachers to improve progress in identified subject	Spring term	Investigate schools’ NTP funding to support individual tuition		
Plan ‘countdown to SATs’ to include rapid progress and exam technique	First half summer term			

Actions	Timescale	Resources	RAG	Impact
Secondary				
LW to work with Titus Salt to bring rapid improvement to English				
Ensure agreement with leadership for the approach – work with new HT (current DHT) - Overcome likely timetabling issues - Ensure curriculum match - CPD for En staff - Maximise En entries	January 2024			

Appendix 6

"Communication and Language, the Key to Children Succeeding"

Launchpad for Literacy

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Rationale

- Up to 50% of children in areas of disadvantage are at risk of starting school with a speech, language or communication difficulty.

- Many of these may be **preventable** with access to good quality ‘talking environments’ and targeted support.

- We need to maximise communication opportunities from the earliest point in life and make sure everyone who works with children knows why this is important.

Launchpad for Literacy

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

1.7 Million Young Futures

- 1.7 million children are struggling with talking and understanding words in the UK right now. Read our new report, 1.7 million young futures, for our findings and recommendations after surveying more than 1,000 families and teachers.

- Most of us take being able to talk and understand words for granted. We don’t think about what our life would be like if we found this difficult. But 1.7 million children are living this reality.

- Without help, they will find it harder to read, write and use numbers as well as learning other subjects. They’ll also face challenges making friends and staying in good mental health and in the longer -term in getting a job and staying out of trouble.

Launchpad
for Literacy

City of
BRADFORD
METROPOLITAN DISTRICT COUNCIL

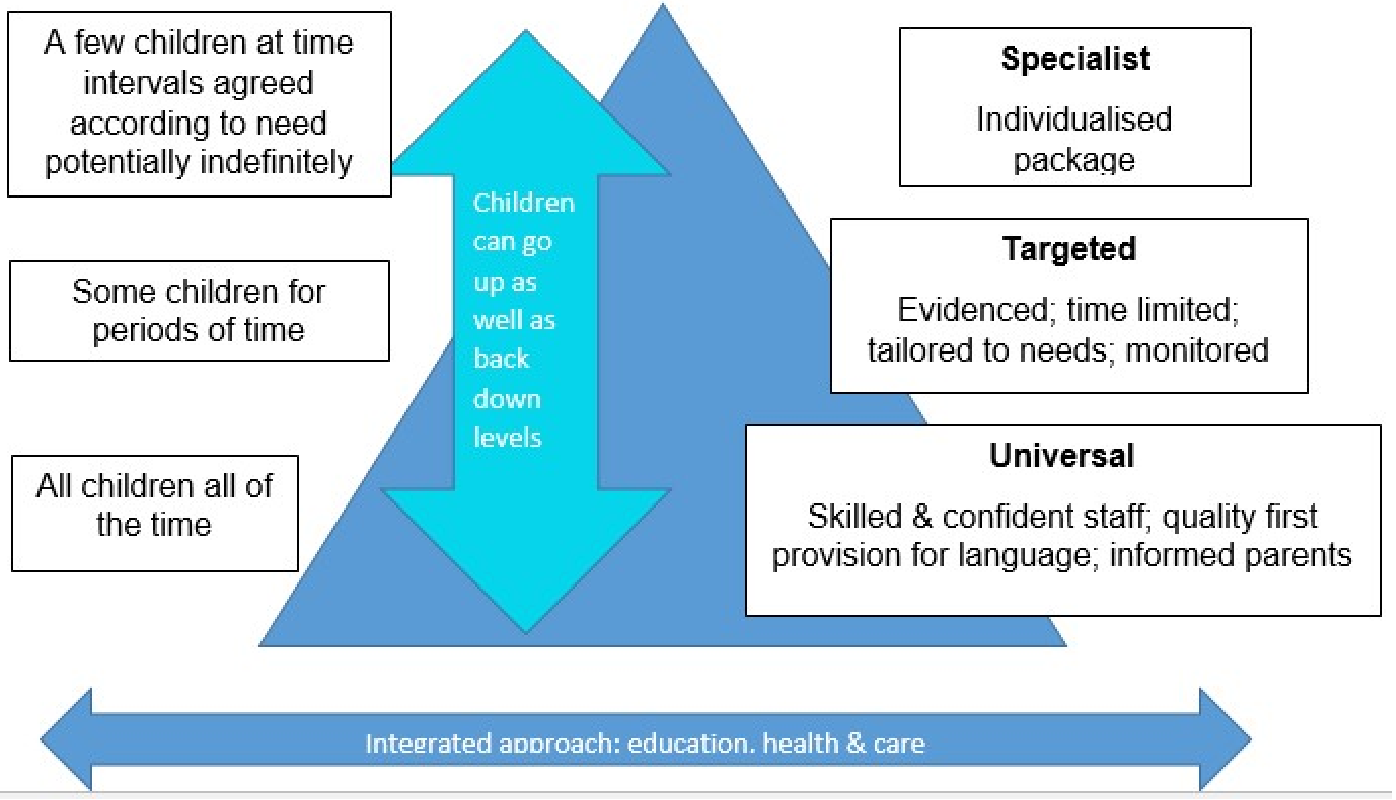
Public Health England: Best Start

- A whole population pathway; where jointly commissioned specialist services informs every level.
- An integrated, system wide **joint** approach with an ongoing workforce development strategy at its core.
- Begins at pregnancy and ends at transfer from Health Visitor to school nurses/ early years setting to school.
- Involves parents at every stage; places their needs at the heart of service design and is communicated to them in ways they understand.

Launchpad for Literacy

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Speech Language Communication Strategy Pathway



A few children at time intervals agreed according to need potentially indefinitely

Some children for periods of time

All children all of the time

Children can go up as well as back down levels

Specialist

Individualised package

Targeted

Evidenced; time limited; tailored to needs; monitored

Universal

Skilled & confident staff; quality first provision for language; informed parents

Integrated approach: education, health & care

City of
BRADFORD
METROPOLITAN DISTRICT COUNCIL

Benefits of using the Launchpad Toolkit

- Shared importance of communication
- Children’s language barriers are identified
- Understanding how we can support speech, language and communication needs
- Early & bespoke targeted support for children
- No child falls through the net
- Consistency and continuity of support
- Improves communication outcomes

Launchpad for Literacy

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

The Project

- 2-year funded support September2023 – July 2025
- Launchpad for Literacy Toolkit
- Lifetime access to the Google Drive
- Nominated Launchpad Leader (preferably the EYFS Leader)
- Attend the Launch Event (Headteacher & EY Leader)
- Initial audit
- 6 x bespoke in school support sessions (during school hours) with a Launchpad for Literacy associate
- 6 x network meetings (after school), virtual 1 per term
- Exit audit
- Lifetime access to ongoing CPD and live webinars from Kirstie Page

Launchpad for Literacy

City of BRADFORD METROPOLITAN DISTRICT COUNCIL