Health and Wellbeing Board Agenda

Date: **Tuesday 24 November 2020**

Time: **10.00 am**

Venue: **Online – Virtual Meeting**

Membership **(Quorum 5)**

Chair:	**Councillor Graham Henson**
Board Members:	
Councillor Ghazanfar Ali	**Harrow Council**
Sheik Auladin	**Clinical Commissioning Group**
Councillor Simon Brown	**Harrow Council**
Councillor Janet Mote	**Harrow Council**
Marie Pate	**Healthwatch Harrow**
Councillor Christine Robson	**Harrow Council**
Javina Sehgal	**Managing Director, Harrow Clinical Commissioning Group**
Dr Muhammad Shahzad	**Harrow Clinical Commissioning Group**
Dr Genevieve Small (VC)	**Chair, Harrow Clinical Commissioning Group**
1 Vacancy	**Harrow Clinical Commissioning Group**
Reserve Members	
Councillor Niraj Dattani	Harrow Council
Councillor Dean Gilligan	Harrow Council
Councillor Maxine Henson	Harrow Council
Councillor Dr Lesline Lewinson	Harrow Council
Councillor Krishna Suresh	Harrow Council
Dr Himagauri Kelshiker	Harrow Clinical Commissioning Group
Rasila Shah	Healthwatch Harrow
1 vacancy	Harrow Clinical Commissioning Group

Non Voting Members:

Inspector Edward Baildon, Harrow & Brent Police
Carole Furlong, Director of Public Health, Harrow Council
Paul Hewitt, Corporate Director - People, Harrow Council
John Higgins, Representative of the Voluntary and Community Sector
Chris Miller, Chair, Harrow Safeguarding Boards
Angela Morris, Director Adult Social Services, Harrow Council
Vacancy, NW London NHS England
Vacancy, Harrow Clinical Commissioning Group

Contact: Mwim Chellah, Senior Democratic & Electoral Services Officer
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Useful Information

Meeting details

This meeting is open to the press and public and can be viewed on www.harrow.gov.uk/virtualmeeting

Filming / recording of meetings

Please note that proceedings at this meeting may be recorded or filmed. If you choose to attend, you will be deemed to have consented to being recorded and/or filmed.

The recording will be made available on the Council website following the meeting.

Agenda publication date: Monday 16 November 2020

Agenda - Part I

1. **Petitions**
To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Board Procedure Rule 13 (Part 4B-1 of the Constitution).

2. **Attendance by Reserve Members**
To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

3. **Declarations of Interest**
To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Board;
(b) all other Members present.

4. **Minutes** (Pages 5 - 58)
RESOLVED: That the minutes of the meeting held on 22 September 2020 be taken as read and signed as a correct record.

5. **Public Questions ***
To receive any public questions received in accordance with Board Procedure Rule 14.

Questions will be asked in the order in which they were received. There will be a time limit of 15 minutes for the asking and answering of public questions.

[The deadline for receipt of public questions is 3.00 pm, 20 November 2020. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

6. **Deputations**
To receive deputations (if any) under the provisions of Board Procedure Rule 13 (Part 4B-1 of the Constitution).

7. **Covid-19 Update [Including Adult Social Care Winter Plan]** (To Follow)

8. **Progress on the Integrated Care System for North West London** (To Follow)

9. **Out of Hospital Recovery Plan/Update** (To Follow)

10. **Adult Social Care Strategy** (To Follow)

11. **Mental Health Strategy** (To Follow)

12. **Harrow Safeguarding Adults Board Annual Report 2019-2020 & Harrow Safeguarding Children's Board Annual Report 2019-2020** (To Follow)

13. **Any Other Business** (To Follow)
REPORT - Focus for Healthwatch Harrow October 2020 - March 2021.

Agenda - Part II - Nil

*** Data Protection Act Notice**

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

HEALTH AND WELLBEING BOARD

MINUTES

22 SEPTEMBER 2020

Chair:	*	Councillor Graham Henson	
Board Members:	*	Councillor Ghazanfar Ali	
	*	Councillor Simon Brown	
	*	Councillor Janet Mote	
	*	Councillor Christine Robson	
	*	Dr Genevieve Small (VC)	Chair, Clinical Commissioning Group
		Dr Himagauri Kelshiker	Clinical Commissioning Group (Reserve)
	*	Marie Pate	Healthwatch Harrow
	*	Javina Sehgal	Harrow Clinical Commissioning Group
		Rasila Shah	Healthwatch Harrow (Reserve)
	*	Dr Muhammad Shahzad	Clinical Commissioning Group

Non Voting Members:		Inspector Edward Baildon	Harrow, Brent & Barnet Police	Metropolitan Police
	*	Carole Furlong	Director of Public Health	Harrow Council
	*	Paul Hewitt	Corporate Director, People	Harrow Council
	*	John Higgins	Voluntary Sector Representative	Voluntary and Community Sector
	*	Chris Miller	Chair, Harrow Safeguarding Boards	Harrow Council
	*	Angela Morris	Director of Adult Social Services	Harrow Council

In attendance: (Officers)	Ayo Adekoya	North West London Collaboration of Clinical Commissioning Groups
	Jackie Allain	Central London Community Healthcare NHS Trust
	Tanya Paxton	Central and North West London NHS Foundation Trust
	Ishtiaq Muneeb	NW-CU
	Alexandra Kalmis	NHS Harrow CCG
	Simon Crawford	London North West University Healthcare NHS Trust
	Seth Mills	Harrow Council
	Lennie Dick	Harrow CCG

* Denotes Member present

14. Attendance by Reserve Members

RESOLVED: To note that there were no Reserve Members in attendance.

15. Appointment of Vice-Chair

RESOLVED: To note the appointment of the Chair of Harrow Clinical Commissioning Group, Dr Genevieve Small, as Vice-Chair of the Board for the 2020-21 Municipal Year.

16. Declarations of Interest

RESOLVED: To note that the Declarations of Interests published in advance of the meeting on the Council's website were taken as read.

17. Minutes

RESOLVED: That the minutes of the meeting held on 14 January 2020, be taken as read and signed as a correct record.

18. Public Questions

RESOLVED: To note that no public questions, petitions or deputations had been received.

Resolved Items

19. Out of Hospital Plan [updated with Glossary] and Implementation Plan

The Board received a report on the Out of Hospital Plan and Implementation Plan which advised on the latest position in the implementation of the Harrow Out of Hospital Recovery Plan, with an updated glossary, and a summary of the North West London Out of Hospital Plan.

Members were pleased with the joint work that had been undertaken to deliver the plan. The joint approach and working was making the local authority and partners more resilient and ready for the next wave of the COVID-19 pandemic, should it happen; and most importantly the citizens and residents of Harrow are receiving the best possible protection from the coronavirus..

RESOLVED: That the report be noted.

20. Care Home Support Plan (Updated)

The Board received the Care Home Support Plan which set out the Harrow response to the national specification – Enhanced Health to Care Homes.

The Harrow care home model had four principal aims:

1) provide residents living in care home the access to the right social care and health services in the place and time of their choosing;

2) deliver high-quality personalised care within care homes;

3) enable effective use of resources for both proactive and reactive care and support required in care homes; and

4) reduce unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care homes.

Members observed that the Voluntary and Community Sector (VCS) continued to be integral in implementing the plan, and were equal partners, who were represented at the weekly health and care executive meetings.

In response to a concern from a Member in relation the restrictions and the rights of residents, it was advised that family visiting to care homes was a key issue, and the messaging to families was important.

Members welcomed the level of competence and capacity training for care home staff.

RESOLVED: To note the report and continue to support the implementation process as part of the Harrow Out of Hospital Recovery Plan.

21. Mental Health and Learning Disabilities

The Board received the Mental Health and Learning Disabilities report, which set out the local Harrow Health and Social Care preparation and response for Mental Health and Learning Disabilities services during the COVID-19 pandemic.

Members noted the omission of autism as a condition addressed in the report.

In response to a Member's question, it was advised that there was a Children and Young People's (CYP) workstream as part of the plan which would cover out of hospital pathways in relation to mental health for children and young people.

Members expressed concern at the low number of local lead reviewers, and were advised that it was envisaged that these would increase in future.

In response to a question from a Member on Section 136 facilities, the Board was advised that there were adequate suites available should they be required. Moreover, patients would not be kept in police holding cells, as they would be directed to available Section 136 suites within the area.

RESOLVED: To note the report.

22. Health and Well-Being Strategy with Obesity Strategy

The Board received the Health and Wellbeing Strategy, which was a statutory requirement. It set out the strategic objectives and focus for the Joint Health and Wellbeing Board and sought to address the health and wellbeing needs of the population of Harrow.

The strategy would cover a five-year period from 2020 – 2025 and had originally been due for presentation at the Health and Wellbeing Board in March 2020. The Strategy had been refreshed with Covid-19 implications.

The Health and Wellbeing Strategy also incorporated the Obesity Action Plan which was based on the needs identified in the Obesity Needs Assessment 2020. The Health and Well-being Strategy will be incorporated into the 10 year Borough Plan now being refreshed in the light of the Covid-19 pandemic.

RESOLVED: That: (1) the Health and Wellbeing Strategy for Harrow be approved; and
(2) a Councillor and a GP be identified, outside of the meeting, as "healthy food champions".

23. Local Outbreak Plans (Plus Update on Contain Framework)

The Board received the Local Outbreak Control Plan which described the multiagency response to prevention of COVID-19, and management of further outbreaks.

RESOLVED: That the Plan be noted, especially the new legal powers and "soft powers" accorded to the Local Authority to help control local outbreaks.

24. Public Health Quarterly Reports [Quarter 3 and Quarter 1]

The Board received the Public Health Quarterly Update Report, which provided two quarterly public health reports: for Quarter 3, which detailed how the public health grant was spent in 2019-20; and for Quarter 1, 2020-21, which reviewed the impact of COVID 19.

RESOLVED: That the report be noted, especially the growing importance of the wider determinants of public health in the economic recovery of the Borough post Covid-19.

(Note: The meeting, having commenced at 12.30 pm, closed at 2.46 pm).

(Signed) COUNCILLOR GRAHAM HENSON
Chair

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The North West London
health and care partnership

Mental Health, Learning Disabilities and Autism

Response to COVID-19 and approach to recovery planning

11 June 2020

Overview

This document provides an overview of North West London's approach to recovery for mental health, learning disabilities and autism (MHLDA) services, following the COVID-19 pandemic.

- A summary of NW London's **response to the pandemic** has been provided upfront, setting out the changes to services, examples of innovation and impact on activity. This section also articulates our **collective principles that will guide the recovery approach**.
- An **overview of our recovery approach** is detailed next. This sets out the key activities against core programme areas that will be the focus of NW London's recovery plan for MHLDA.
- The final section aims to provide **additional detail on key areas that will require collective action following the pandemic**, e.g. addressing health inequalities. This section also **demonstrates alignment with national and regional expectations**.

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This document is…

- A summary of the key activities that make up NW London's approach to recovery for MHLDA.
- Intended to articulate some of the core issues that need to be addressed collectively by all partners across the system.
- A tool to capture some of the innovation that took place during the pandemic, to help ensure this is built upon and learning is taken forward into the recovery phase.

This document is not…

- A detailed delivery plan for achieving the NHS Long Term commitments; this information has been set out elsewhere.
- An exhaustive overview of all activities that have/will take place to improve services for our MHLDA patients.
- A completed document – it's intended that this plan will be refined as we continue to engage with system partners.

The North West London
health and care partnership

The North West London COVID-19 Response for Mental Health, Learning Disabilities and Autism

North West London partners have come together to make rapid services changes in order to deliver safe MHLDA services for our residents during the pandemic

Rapid response	Impact on activity	Learn and move forward
During the pandemic, a number of **rapid service changes** were enacted and steps taken across MHLDA in response to national guidance, and to prioritise patients with greatest need in the context of volatile staffing levels.	The COVID-19 pandemic impacted **MHLDA activity across all settings**; further work is needed to understand the reasons behind these observed changes.	It will be important to **sustain positive changes and ways of working, and learn from this period.** A set of principles will be developed to guide the MHLDA recovery approach.

There has been significant innovation across services: examples of success

Rapid service changes

- Providing **alternatives to assessment in A&E**/ admission through MH Emergency Centres/ Hubs.
- **Increased community based crisis response** (CRHTT & CATT offer 24/7).
- **Better flow through inpatient** care e.g. consolidating wards and improving bed usage.
- Strong focus on **ensuring the safety of patients in the community** e.g. assertive outreach, including collaborative working with voluntary sector and primary care.
- Focused and **proactive work on supporting shielded patients** and those most at risk across both CNWL and WLT.
- **Sharing resources/cross cover** between boroughs and localities.
- **Enhanced digital offer** to provide alternatives to face to face offer.
- **Enhancing IAPT pathways** and health psychology services to provide mental health support to NW London staff during the pandemic.
- Use of **enhanced dynamic support registers** for high-risk LDA patients.

Integration of physical and mental health care for people with SMI

- **Increased digital offer** to ensure safety of patients with SMI are provided with continued support and care.
- **Joint working** between community teams, mental health inpatient teams and crisis teams to provide **accelerated discharges**, and some have explored 7-day working.
- **Community based approaches** in place to support shielding patients.

Mental health emergency centres and hubs

- To provide an **alternative for some mental health patients who sometimes experience long waits in A&E** to be assessed in a mental health emergency centre/ hub to alleviate pressure on A&E.
- Enable the **physical screening of patients requiring admission** to optimise correct bed allocation.
- Ensure all potential **admissions (including those under the MHA) meet the raised threshold** for admission.
- CNWL services at: Hillingdon Hospital, Northwick Park Hospital and Brent HBPoS for outer boroughs and for inner boroughs the unit is located at St Charles Hospital.
- WLT services at: Hammersmith & Fulham Mental Health Unit (Charing Cross Hospital site), Lakeside Mental Health Unit (West Midd. Hospital site) and Wolsey Wing at St Bernard's (Ealing Hospital site).

The pandemic, initially, had a significant impact on MHLDA activity:

Fewer admissions, no readmissions and decreased inpatient lengths of stay

Higher number of people with SMI cared for in the community

Increased use of virtual appointments/ telemedicine for some services e.g. IAPT; some other services have moved to full virtual operation e.g. perinatal mental health

Fewer CAMHS (community and specialist) referrals

Decreased activity via Single Point of Access

As more recent data comes through, we are now:

1. Observing an upward trend in demand as we enter the recovery phase
2. Better understanding some of the impacts that the pandemic has had

Adult **12-hr breaches** for MH patients across London in ED have increased; **attendance in NW London has remained low**.

71% increase in adult MH presentation to London's EDs; attendance in **NW London has decreased during May**.

Referrals to the Liaison Psychiatry Teams have been increasing since mid-April.

Referrals to crisis teams for both adults and CYP are now increasing.

The number of reported **deaths of people with learning disabilities** during April 20 was double that of those reported in March and May 20.

A set of principles will guide the MHLDA recovery approach

- Acknowledged that delivering Long Term Plan commitments remain critical to improving MHLDA care in NW London, and will now be in the context of increased demand and greater morbidity.
- Consideration to health inequalities and vulnerable groups including BAME communities is vital.
- Coproduction work with neighbourhoods, service users, carers and their families will be vital in the next phase, particularly those who are new to our services. This will include a wider range of communication channels.
- Focus must be on delivering services safely in community and only bringing people to inpatient care settings when absolutely necessary. Facilitated by greater use of digital/ virtual services.
- Phased approach, coordinated across MHDLA and primary care including ensuring that GPs have ongoing access to specialist advice and guidance.
- Building on good joint work with Local Authorities during pandemic i.e. expedited discharges, provision of community support resources.
- Strong clinical leadership has been key to response – this needs to be maintained.
- Need to understand positive impact of staff redeployments, and review ways that workforce has come together to collaboratively support patients. Agree elements that should continue.
- Review and maintain positive system wide changes/ways of working.

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The North West London Recovery Plan for Mental Health, Learning Disabilities and Autism

Now: The COVID-19 pandemic will likely lead to greater need for mental health services from people who stayed away or who are now caught up in its tailwinds

Ambitious	Some ambitions of the NHS Long Term Plan commenced during the pandemic; services worked together and other options (including digital care) were offered and will continue, of high quality, as directed by need.
Safest place	There will be more safe and satisfactory choices for people in crisis, avoiding A&E and admission, with more home treatment and greater community and voluntary sector support (phone, digital and face to face).
Local	Community teams will cover more days and longer times, for more local care and treatment, from a local system, including voluntary sector, that works together to enable people to take better care of their mental and physical health together and builds confidence in people.
From 0 to 25 years	Single points of access to services, more digital options, meeting new demands from services missing during Covid (like schools); strengthen liaison between local NHS and non-NHS partners, with better transitions to adult services.
Learning Disabilities & Autism	Keep people mentally and physically well, with right support in right place so hospital not always necessary; greater support for families and all services to guard against exclusion from service offer, including digital.
Staff	Skilled and supported; bringing more physical and mental health skills together in services and staff; support for those who have delivered care in challenging times.
For everyone	To provide what each person needs, to reach the most vulnerable families and people, care close to home and NHS Staff.

What this means for patients, staff, carers and families

Better use of digital technology to deliver safe, flexible care

- Harnessing the **full range** of digital technology to offer greater choice and responsiveness for the different needs of patients, carers and families, with a strong focus on **support and treatment at home**, using the expertise of community teams and the voluntary sector.
- **Better use of digital technology** will be balanced with support and treatment over the phone and face to face, so that all patients can get the care they need, when they need it, in the way which works best for them. This balance is critical for **vulnerable people and their families** – such as BAME communities (disproportionally affected by Covid-19) and those with learning disability and autism – to **address persisting inequalities and the risk of digital exclusion**.

Easy access to the right care and support, with prompt response in a crisis

- Providing a **range of choices** for safe, high-quality care and support to **keep people mentally and physically well** – avoiding A&E and admission to hospital, wherever this is safe.
- **Community teams will be central to this** as part of a local system, including the voluntary sector, working together and building people's confidence to take care of their mental and physical care.
- For **children and younger people**, for example, this will include better access to single points of access to services, specialist support in schools, with smoother transition to adult services.
- There will **be greater choice for people in crisis** (phone, digital and face to face), focusing on proactive support and delivering care in the safest place for them, out of hospital, wherever possible. This will include mental health emergency centres, for example.

Different ways of working and supporting our staff

- Providing **support for staff to develop** the necessary skills to care for people's physical and mental health together, with greater ability to work remotely, where appropriate.
- **Wellbeing and psychological support** for care professionals is critical for the health and resilience of staff, such as the recently-launched **Keeping Well service** for health and social care staff across North West London. This service delivers psychological assessment and therapy, with a choice of face to face, phone and live chat.

Coproduction will be vital in the next phase

- For mental health, learning disabilities and autism, coproduction work with neighbourhoods, service users, carers and their families will be vital in the next phase, particularly those who are new to our services. This will include a wider range of communication channels.
- We will continue to use our co-production model with our established expert by experience and service user groups across NW London to ensure that lived experience is central to our service offer in the recovery phase.
- We also recognise the need to refresh our co-production model to reach wider voices that will influence service delivery, and to listen and reflect more. We will use the learning from the Grenfell Tower disaster and work alongside the community to adapt our services.

The North West London
health and care partnership

Responding to national and regional expectations

Meeting national and regional expectations

- This section sets out how NW London is responding to the NHS England and NHS Improvement requirements: **7 clinical priorities; 12 expectations; 8 tests.** See Appendix 1 for full detail of requirements.
- Alignment with national guidance on the second phase of the COVID-19 response (letter from Simon Stevens and Amanda Pritchard) is covered in Appendix 2.
- Key questions for consideration from NHSE/I London are outlined in Appendix 3, for reference.

7 Clinical Priorities	
1	Determine configuration of C19+ inpatient beds
2	Building community capacity
3	Strengthen dedicated MH crisis pathways
4	Access to appropriate psychological support
5	Increased demand in acuity for CYP
6	Address increased demand in drug and alcohol
7	Address access to trauma services

12 Expectations	
1	Service segregation
2	Critical care
3	Virtual by default
4	Single point of access
5	New approaches to LTCs
6	Minimise hospital stays
7	Focus on inequalities
8	Specialist consolidation
9	Corporate & clinical support services
10	Workforce
11	Institutional alignment
12	Public consent

8 Tests	
1	Covid Treatment Infrastructure
2	Non-Covid urgent care
3	Elective care
4	Public health burden of pandemic response
5	Staff and carer wellbeing
6	Innovation
7	Equality
8	The new health and care landscape

Priorities for recovery: Crisis Care

Mapping against London Clinical Priorities (Appendix 1).

Crisis There will be more safe and satisfactory choices for people in crisis, avoiding A&E and admission, with more home treatment and greater community and voluntary sector support (phone, digital and face to face)

- Increased use of **Single Point of Access** for crises and continue use of enhanced SPA.
- Better **information/ record sharing** to support crises (all parties) and when patients are placed out of area.
- Understanding the **impact of digital exclusion**.

3.

- Provision of **a flexible response to changes in demand and in capacity**; and also to protect the highest risk patients across services.
- **New models** for responding to inpatient/ CATT / CRHTT discharges and to high risk patients identified by ED attendance (building on LTP expansion plans).
- Provision of mental health support to patients e.g. those who have been treated in ITU and **bereavement support to families** where loss and grief will mean a greater demand for support services.

3. 4. 7.

- **New models** for responding to inpatient/ CATT / CRHTT discharges and to high risk patients identified by ED attendance (building on LTP expansion plans community crisis care).
- Improving the **mental health emergency pathway.**
- Elimination of **OAPs**.
- Maintaining **safe provision of care** for staff and patients in inpatient settings where consolidation or changes to services may remain, and where there may be future requirements for cohorting and flexible staffing due to COVID-19 surge.

1. 2. 3.

Priorities for recovery: Community Care

24

Community Community teams will cover more days and longer times, for more local care and treatment, from a local system, including voluntary sector, that works together and builds confidence in people to take more care of their mental and physical health

- **Evaluating the impact of alternative means of patient contact** – making best use of available IT equipment, telemedicine and increase the ability for staff to work remotely.
- Understanding the **impact of digital exclusion**.
- **Information/ record sharing** including accelerating the sharing of patient information (via clinical systems) between primary and secondary care.
- Using **population health data** to ensure that resources are targeted at those most in need, whether based in primary or secondary care.

2.

- **Capacity planning for anticipated increase in demand** for low level psychological support amongst the general population to ensure increased access without impacting waiting list length. Consideration to support needed for those who have experience domestic violence.
- Ensuring **increased access in IAPT (and adherence to national model) and EIP services** in line with previous LTP expansion plans.
- **Strengthening community provision through CMHTTs and CRHTTs** and focus on meeting the needs of people with SMI in the community who may not have been able to access services.

2. 4. 7.

- Providing **planned proactive care**, particularly for shielded/ vulnerable patients.
- **Acceleration of new models of community care** linked to PCNs.
- Utilising resources in the community better, **working more closely with LA and VCSE** organisations.
- Exploring new ways to ensure that the monitoring and **optimisation of the physical health of people with SMI** continues.
- Rapid assessment of the best way to undertake **Dementia memory assessments**.

2.

Priorities for recovery: Children and Young People

Mapping against London Clinical Priorities (Appendix 1).

CYP Single points of access to services, more digital options, meeting new demands from services missing during Covid-19 (like schools); strengthen liaison between local NHS and non-NHS partners, with better transitions to adult services

- Refine models of **digital/remote consultations to support access and outcomes** for existing CYP caseload.
- Increased engagement with CYP (and families/carers) on challenges/ opportunities.
- Work required to **support CYP who are less able to access services** e.g. where English is not the first language.

2. 5.

- Continue to refine **model for CAMHS emergency hubs/crisis pathways** in line with emerging need Develop consistent approach across NWL.
- Further work required to **understand current trend of low referral numbers and anticipated increase in presentation of anxiety, social issues** etc. in CYP due to lockdown.

2. 3. 4. 5.

- Strengthen **liaison with local NHS and non-NHS partners to ensure referral pathways are developed** and aligned to address emerging needs.

2. 5.

Priorities for recovery: Learning Disabilities & Autism

Community Keep people mentally and physically well, with right support in right place so hospital not always necessary; greater support for families and all services to guard against exclusion from service offer, including digital

- Coproduction with experts by experience to **review the successes/challenges of technology usage** to inform future plans.
- Explore use of **digital technology to improve access to autism diagnostic assessments** and bolster **post diagnostic support,** acknowledging that autistic CYP and adults without a LD may have gone without support during the pandemic.
- Use of **technology to support C(E)TRs,** quality assurance visits, and **annual health checks**.

2. 5.

- Recognising and providing **support to families of young people/adults with LDA** and challenging behaviours where lockdown/isolation will have had a significant impact on the family's ability to cope.
- Focused work with **care homes/supporting living to rollout out enhanced support offer** that has been in place for elderly care homes recognising the impact that isolation will have had on the LDA cohort.
- Focus on **discharge planning & quality assurance**.
- Continued focus on **fast track mortality reviews** of COVID related deaths with renewed commitment to prioritise the **timely completion of LeDeR reviews.**
- Improving inpatient care for autistic adults using MH services through new **specialist autism posts.**

1. 2. 4. 5.

- Ensuring that **lived experience of people during the pandemic**, and their families/carers drives our recovery approach.
- **Enhanced, collaborative working between current providers, the voluntary sector and specialised providers** of services e.g. positive behavioural support to **develop alternatives to traditional support** and ensure a wrap around, therapeutic offer is in place for people with LDA and their families including access to psychological support.
- **Enhanced Dynamic Support Registers (DSR)** including multi-agency planning for all people with LD, autism or both whose physical and / or mental health is most impacted by COVID-19.

2. 3. 5.

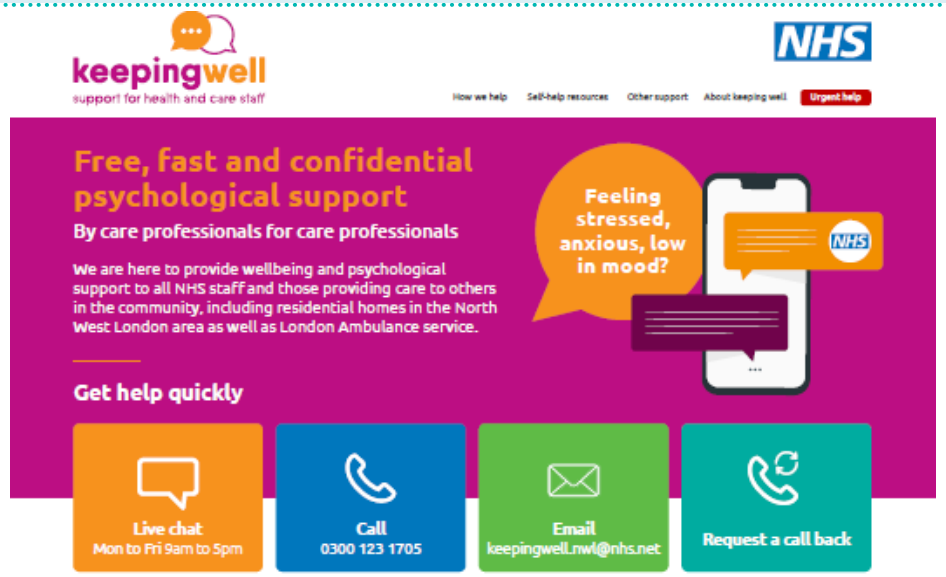
Priorities for recovery: Supporting our staff

Mapping against London Clinical Priorities (Appendix 1).

Supporting our staff Skilled and supported; bringing more physical and mental health skills together in services and staff; support for those who have delivered care in challenging times

- The comprehensive staff 'Keeping Well' service has now been launched covering all NW London NHS (primary care, community, acute and mental health) and social care staff including admin staff. The service is also available to the London Ambulance Service.
- It will provide access to psychological assessment and evidence based therapy at a choice of location with both day and evening appointments being available.
- This can be accessed via email with live chat with a therapist, phone and via the website.

26 3. 4. 7.



The North West London health and care partnership

Ambitious

Aligning our offer across NW London: ensuring consistency and value

Aligning our work and delivering better outcomes and value

North West London Mental Health Partnership

- Prior to COVID-19, the NW London Mental Health Partnership Programme was established to examine spend outside of our main providers with a view to identifying opportunities to deliver better outcomes for NW London patients and families, and ensure better value for money.
- The work initially focused on complex placements to ensure that these remain within the NW London footprint, where possible.
- This programme will continue, and we are now exploring opportunities build on this work and establish a NW London Provider Collaborative. (Appendix 4)

Improving consistency of offer for our patients

Memory Services

- Clinical teams across WLT and CNWL are working together to develop an aligned approach to restarting memory services.
- This is in response to recent letter acknowledging that memory services will not be able to operate in the same way as they did pre-COVID-19 due to the risks inherent in face to face appointments with older vulnerable individuals
- Teams are working together to model staffing numbers required to open services to all new referrals and develop a remote working policy to conduct remote cognitive assessments either by video/ tele-consultation; and re-open groups.
- The plan is to re-open services to routine referrals by 1st July 2020.

A single, consistent NW London CAMHS service

- Providers and commissioners came together pre-COVID-19 to develop a consistent specification for specialist CAMHS services (Tier 3).
- This was in response to a common ambition to: (1) provide a unified offer for CYP across NW London; (2) minimise variation; (3) help stop CYP ‘falling through gaps’; and (4) ensure better alignment to the THRIVE model.
- As we move into the recovery phase this work will be finalised and the new specification implemented.

Ambitious

Increasing our digital offer

- We will continue to work with our partners across London to promote existing digital offers for wellbeing support and resilience
- The use of virtual and remote consultations has allowed the majority of mental health services – including some specialist services such as virtual CPA, ward rounds and patient assessments for high secure services – to continue uninterrupted. Face to face contact where required has been possible for urgent care and treatment.
- Services will continue offering treatment via virtual and remote solutions until it is safe to restart face-to-face appointments where required, and different platforms that will allow expansion of current virtual group offers are being explored. For example:
    - Attendanywhere that can be linked to patient records.
    - Autism diagnostic tool 3di which is completely software led, and reduces the need for face to face contact.
- We will explore the continuation of delivering some services in a virtual way where we have seen great success during the COVID-19 period e.g. perinatal mental health services and carer events.
- At the same time we recognise the need to consider a person's preferred communication style and ensure alternatives to virtual are readily available for some groups who may struggle to use technology effectively e.g. people with learning disabilities, autistic people, people who use English as a second language and older people. To this end, we will work with our population to ensure the development of a sustainable, appropriate and meaningful virtual offer as a choice for patients and families.

28

- Set up 1 week trial
- Enable technology – software and hardware
- Provide written guidance
- Provide technical support
- Enable staff choice

- Check usage by services, patient cohorts and staff groups
- Check early service user feedback
- Gather early clinician feedback
- Understand barriers to access for clinicians and service users

- Examine data
- Strategic steer
- Plan ahead
- Methodology
- Resources
- Governance

- Systematic , evidence-based and coproduced approach
- Trust wide training and support
- Engage with L&D to support
- Systematic setting up of systems and reporting mechanisms

- Impact on inequality assessed as a priority
- High-quality evidence to check effectiveness of treatment, engagement, DNA rates etc.
- R&D leads across the Trust engaged
- Academic links established

Safest place

Service segregation – safe inpatient and community care

- We will maintain safe provision of care for staff and patients in mental health inpatient settings where consolidation or changes to services may remain, and where there may be future requirements for cohorting and flexible staffing due to COVID-19 surge.

Delivering care that keeps both staff and patients safe will be guided by **two key principles** in accordance with London guidance

Principle 1: confirmation of COVID-19 status

- Access to NHS care sites for all patients and staff is determined by their COVID status (screening, testing)
- Access controlled by exemplary IPC and PPE compliance
- Access controls must maintain equitable access to healthcare

Principle 2: segregation by COVID-19 status

- Separated pathways for urgent and planned care to aim to eliminate risk of nosocomial infection: (1) physically separated; and (2) staffing separated
- COVID protected: elective care pathways for test negative COVID-19 patients
- COVID risk managed: urgent and emergency care in a defined zone and reduce risk of nosocomial transmission when care cannot be delayed/testing status of patient not known

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Community

Delivery of proactive/planned care & model of care for shielded patients

- Needs-centred pathways, building on COVID-19 learning and work to date for pathway delivery.
- Alongside continued inpatient COVID-19 isolation spaces, PPE, uniform, and planning for COVID-19 bed use with future blue/green pathways.

Embedding talk before you walk- virtual first and single point of access

- Continued use of existing SPA to support mental health advice and signposting
- Development of framework for virtual “offer” & digital enablers, building on feedback from staff and patients on their experience and environment.

Out of hospital pathways’ – including for patients with COVID-19

- Primary-community mental health transformation; community based crisis care and alternatives to admission.
- Development of framework for virtual “offer”.
- Workforce changes to enable continued offered in line with social distancing.

Access to staff testing

- All work underpinned by robust staff testing process that will keep our workforce and patients safe, building on set up to date and moving into new testing hub model.

Safest place

Providing a range of choices for safe, high-quality care and support to keep people mentally well

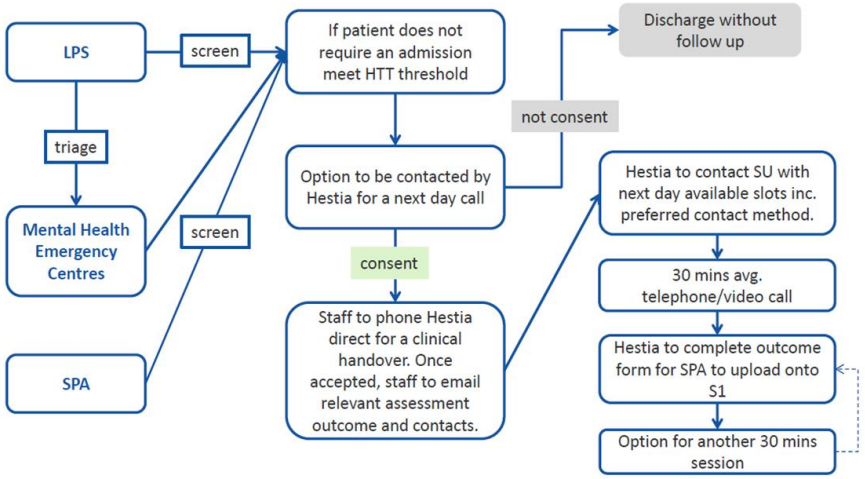
Single point of access

- In NW London we have well established SPAs for access to community and mental health, learning disabilities and autism services. We will continue to build on the existing service models and those put in place in response to the pandemic to enhance our offer, in particular with regards to ensuring increased senior clinical input and that COVID-19 status is determined and subsequent care delivered in line with NHSE/I requirements.
- We will continue to refine the model for CAMHS emergency hubs/crisis pathways in line with emerging need; developing a consistent approach across NW London.
- Through our SPAs, we will also make of use of technology to enable screening for eligibility for specialist learning disability and autism and community services as well as reinforcing the need to flag patients with learning disabilities to ensure reasonable adjustments are made to the triage process, along with the necessary links to specialist services and the Dynamic Support Registers.
- Referrals for forensic mental health services should also come through a similar route.

Supporting alternatives to admission

the cove

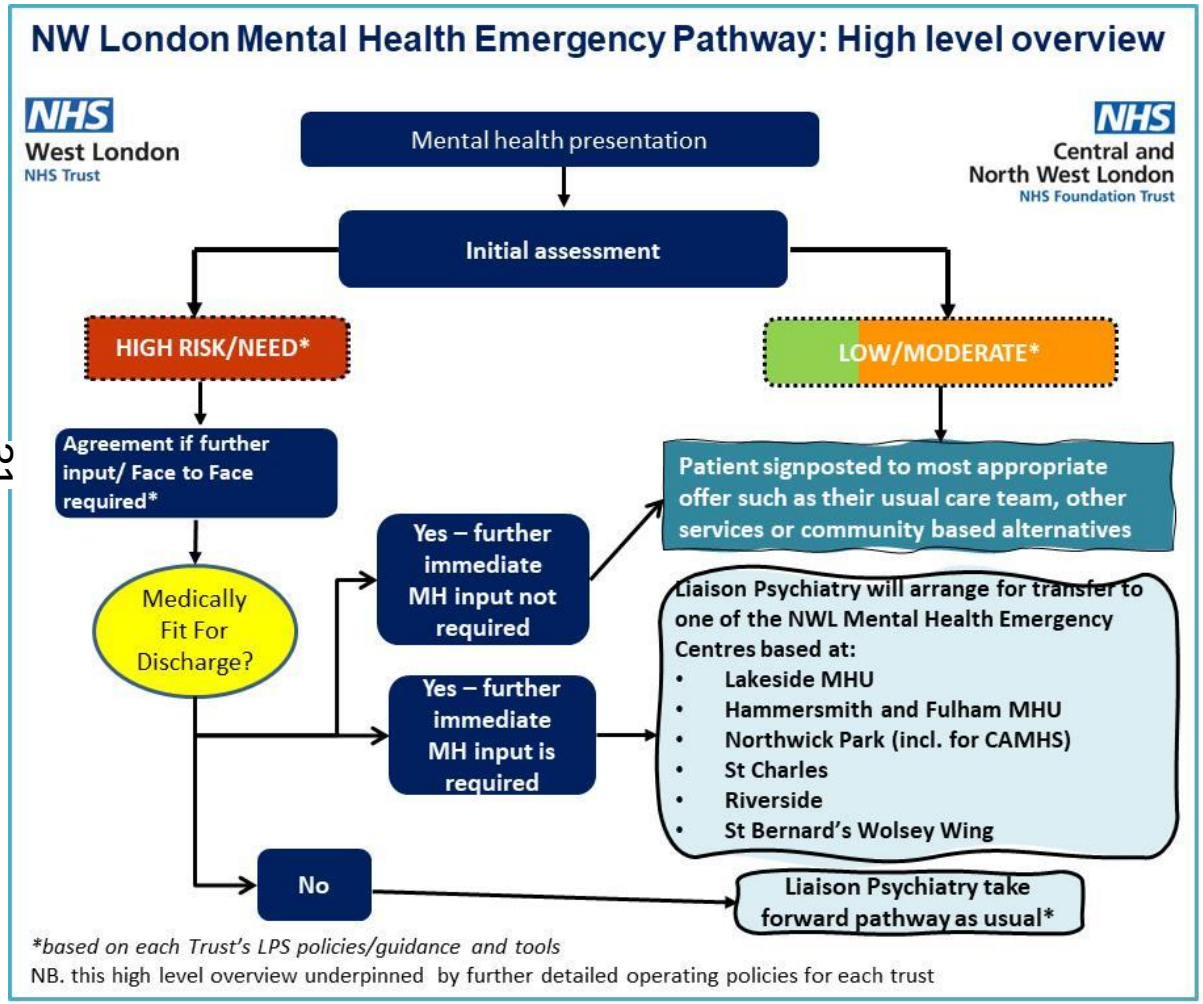
Amadeus Recovery House



- We will maintain work across teams and organisations to identify and enable more alternatives to admission for people presenting in crisis.

Safest place

Improving the mental health emergency pathway

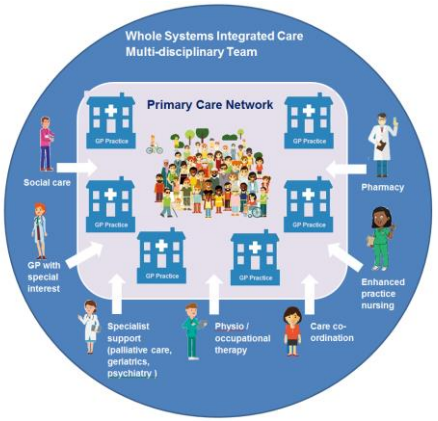


- During the pandemic, Mental Health Emergency Centres and Hubs were established in both the CNWL and WLT footprints to help provide appropriate crisis care for mental health patients and reduce pressure on acute A&Es.
- Following evaluation, we will embed a model of care for our mental health emergency pathway across NW London, linking in with NHS111 and the London Ambulance Service. This will be aligned to the new models for responding to inpatient/ CATT/ CRHTT discharges and to high risk patients identified by A&E attendance.
- **Investment is required to ensure our estate for emergency care and inpatient care is fit for purpose (improving old dormitory style wards).**

Local

New approaches to long term conditions

- We will continue our strong focus on **ensuring the safety of patients in the community e.g. assertive outreach**, including collaborative working with Local Authorities (LA), the voluntary sector (VCSE) and primary care. We will also build on the joint working with Local Authorities on our approach to preventing long term conditions.
- Sharing resources/cross cover between boroughs and localities will allow **provision of planned proactive care, particularly for shielded patients**. In particular, building on the primary care guidance and virtual ward rounds, we will explore and trial virtual annual health checks for people with learning disabilities who are shielding or symptomatic.
- We will build on the experience of patients and clinicians to develop skills to **support and empower self-care**, reducing health seeking behaviours and developing models of care which are more holistic.
- Our well established pathways to **support IAPT-LTCs**, particularly in diabetes, chronic pain, heart failure and cardiac rehab will continue.
- We are exploring new ways to ensure that the **monitoring and optimisation of the physical health of people with serious mental illness** (SMI) continues. Working with PCNs and strengthening of community provision through CMHTTs and CRHTTs will continue and focus on meeting the needs of people with serious mental illness (SMI) in the community who may not have been able to access services during the pandemic.

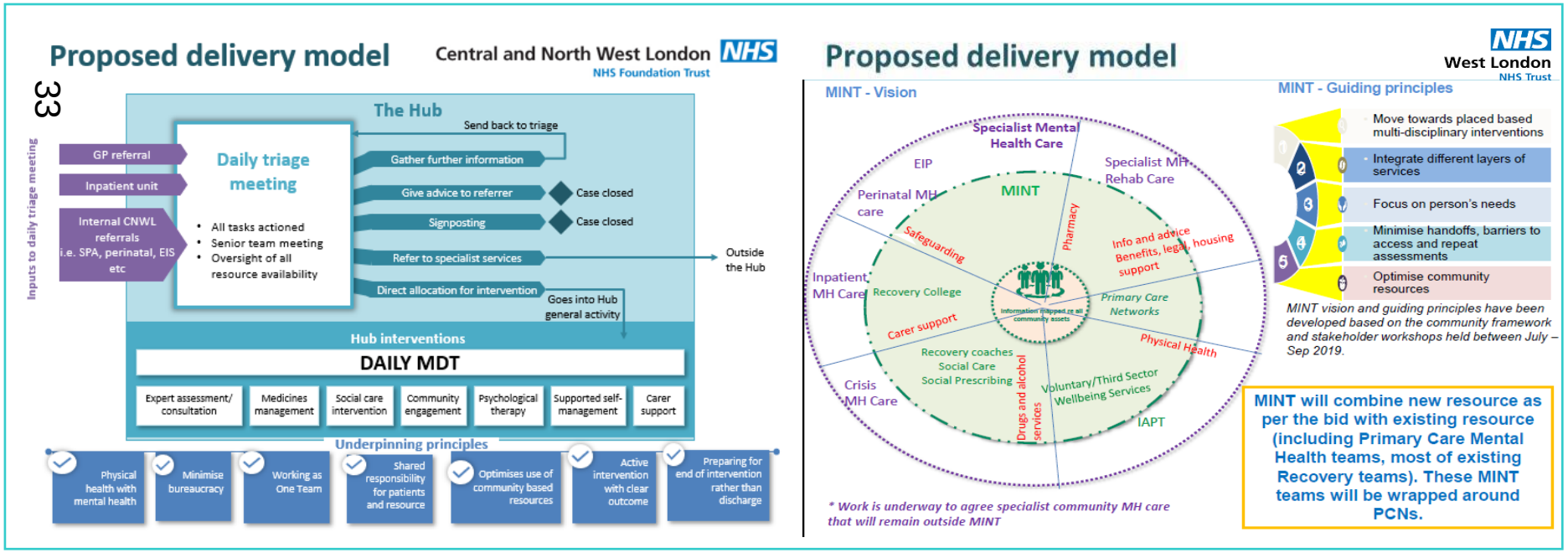


- Capacity planning is underway for the **anticipated increase in demand for low level psychological support** amongst the general population to ensure increased access without impacting waiting list length.
- We will continue the use of **enhanced Dynamic Support Registers to promote multi-agency planning** and target support for people with learning disabilities, autism or both whose physical and / or mental health is most impacted by COVID-19, including those who are shielding or symptomatic.

Local

Improving the integration of physical and mental health

- A vital element of this work will be the acceleration of our transformation work to deliver new models of community mental health linked to PCNs will continue for those SMI. Part of this will involve utilising resources in the community better and working more closely with LA and VCSE organisations. We will also work to accelerate our new service offer for 18-25 year olds.
- These models will be developed and implemented, incorporating learning from Covid-19 and building on some gains made re; caseload review during emergency response whilst following direction of travel for mental health in the Long Term Plan.
- Delivery will incorporate development of what a virtual/digital offer might look like taking learning and feedback from staff and patients during COVID-19 crisis and ensuring accessibility to those who are shielding.



The North West London health and care partnership

Local

Support to shielded patients

Check and Chat services:

- Provided for patients across NWL who were advised to ‘shield’ and other vulnerable patients who were self isolating.
- Trusts used innovative approaches to resourcing their teams in the context of significant staff shortages; teams were made up of trained volunteers, community support workers, many of whom were furloughed BA staff and psychology graduates who were supported and supervised by qualified staff.
- Vulnerable and shielding patients were contacted to ‘check in on them’.
- Patients were signposted to services or support within the local community, invited to talk about any concerns they had, and discussed various aspects of wellbeing, diet, lifestyle and physical and mental health.

Future work across primary, community and mental health care:

- A shielded patient protocol for primary care was in place during the pandemic – supported by the WSIC dashboard – to ensure there was appropriate and consistent action taken to manage the needs of the shielded cohort across NW London.
- As we move into the recovery phase, a diagnostic review will examine the various ways that providers worked to support these vulnerable patients during the crisis.
- Mental health teams will work collaboratively with partners to deliver an ongoing programme for shielded patients that best meets the needs of local populations.

From 0 to 25 years

Supporting children and young people and their families

- Transformation work in line with the **THRIVE model** already in progress for CYP mental health services will contribute to meeting the needs of CYP in NW London and their families, including:
  - ✓ Roll out of **Mental Health Support Teams** in schools.
  - ✓ Development of a **comprehensive 0-25s** offer.
  - ✓ Enhanced **digital support** to improve access and reach.
  - ✓ Joint work with **primary and community, schools and VCSE** to support vulnerable CYP.
  - ✓ An **enhanced crisis offer** during the pandemic, providing 24/7 triage service for CYP diverting them away from A&E.

Supporting our most vulnerable children and young people

Our immediate response…

- ✓ **Services reorganised:** RAG rating of all CYP ensured continued specialist MH offer to all priority cases.
- ✓ **Locality reconfiguration:** to absorb emergency activity onsite and divert away from A&E.
- ✓ **Remotely enabled staff:** ensured continuity. Only 30% reduction in BAU activity over the 3 months of crisis.
- ✓ **Focused:** Crisis Teams focussed on home treatment, A&E and T4 diversion to reduce unscheduled attendance and psychiatric admissions.
- ✓ **Remote group support:** offers developed to include DBT groups; crisis support for service users, parents and carers; and parenting support for ADHD/ASD patients.

Next steps…

- ❖ **Proactive engagement with key partners** – LA, VCSE and participation in Vulnerable Children's Panels – to ensure join up of services, and provide offer of support from Trusts to partners.
- ❖ **Outreach by local CAMHS to schools** (including specialist schools) to support them in recognising MH issues and understanding routes to services. Working to support CYP who won't return to school this summer.
- ❖ **Proactive contact with CYP on caseloads**, prioritising most at-risk. Supporting continued provision of T2 offer remotely with partners.
- ❖ **Partnership with VCSE to offer parenting support** for parents facing difficulties supporting CYP during the lockdown to help build resilience and ability to self care.

Learning Disabilities & Autism

Supporting children and young people with LDA and their families

- In line with the NHS Long Term Plan commitments, the use of Dynamic Support Registers (DSRs) and Care, Education and Treatment Reviews (CETRs) for CYP with LDA at risk of admission to a tier 4 setting are already well established. Transformation work is already in progress to improve the autism diagnostic pathways and to develop an improved short breaks / respite offer for CYP with LD and challenging behaviour and their families
- Our partners in education and social care are working with the Trusts to develop a register to identify and reach out to the wider population of CYP with LDA who have special educational needs, who may not have been in school and are especially vulnerable throughout the COVID-19 period.

Immediate steps to reach out to vulnerable CYP

1. Accelerated roll out of Positive Behaviour Support provided by the independent sector to compliment and add capacity to existing local provision for CYP with LDA and their families.
2. Increasing the frequency of DSR forums to provide priority oversight for people at risk of tier 4 admission or community breakdown, and use of technology to ramp up virtual community CETRs to plan person centred support to avoid admission
3. Reaching out to all CYP on LD caseloads to provide welfare checks, remote consultations, parenting guidance and support, and signposting to the Local Offer websites

Enhanced Registers for CYP with LDA

The Dynamic Support Registers which provide a multi-agency process for identifying and planning coordinated support and agreeing funding for CYP at risk of tier 4 admission have been adapted to allow similar planning for all CYP with LD, autism or both who have an Education, Health and Care Plan.

The new registers have been developed at pace to identify CYP with physical and / or mental health needs who will be most impacted by COVID-19. This includes CYP with health conditions who fall into the vulnerable category, those with complex/fragile family dynamics, those affected by school or college closures as well as CYP who struggle to comply with social distancing or shielding. In addition to identifying support for families, and the frequency of welfare checks, a risk stratification and assessment process is used to determine place of learning and to support transition back to school or college

Learning Disabilities & Autism

Supporting adults with LDA and their families

- ✓ **Lived experience** of people with a LDA during the pandemic will guide NW London's recovery approach. We know that this cohort has been affected in ways that are different and more acute compared to others – our experts tell us that the effects of isolation, psychological distress and changes to usual support services have had a significant impact.

Some aspects of our recovery approach are mandated by NHS England and NHS Improvement. As a system we must…

- Continue to **deliver against our inpatient trajectory**. We are on target to meet this; despite the pandemic discharges from inpatient settings have continued.
- Resume and **improve our annual health check performance**. 2019/20 (up to Q3) performance ranged between 24 and 75%. This needs to be 75% across all CCGs.
- **Improve performance on C[E]TRs**. This has been a particular issue in NW London. A stocktake is underway and a designated coordinator is being recruited.
- Address premature mortality of people with LD through timely completion of **LeDeR reviews** and addressing recommendations.
- Improve quality of inpatient care via **implementing host commissioner arrangements** and **6-8 weekly visits.**

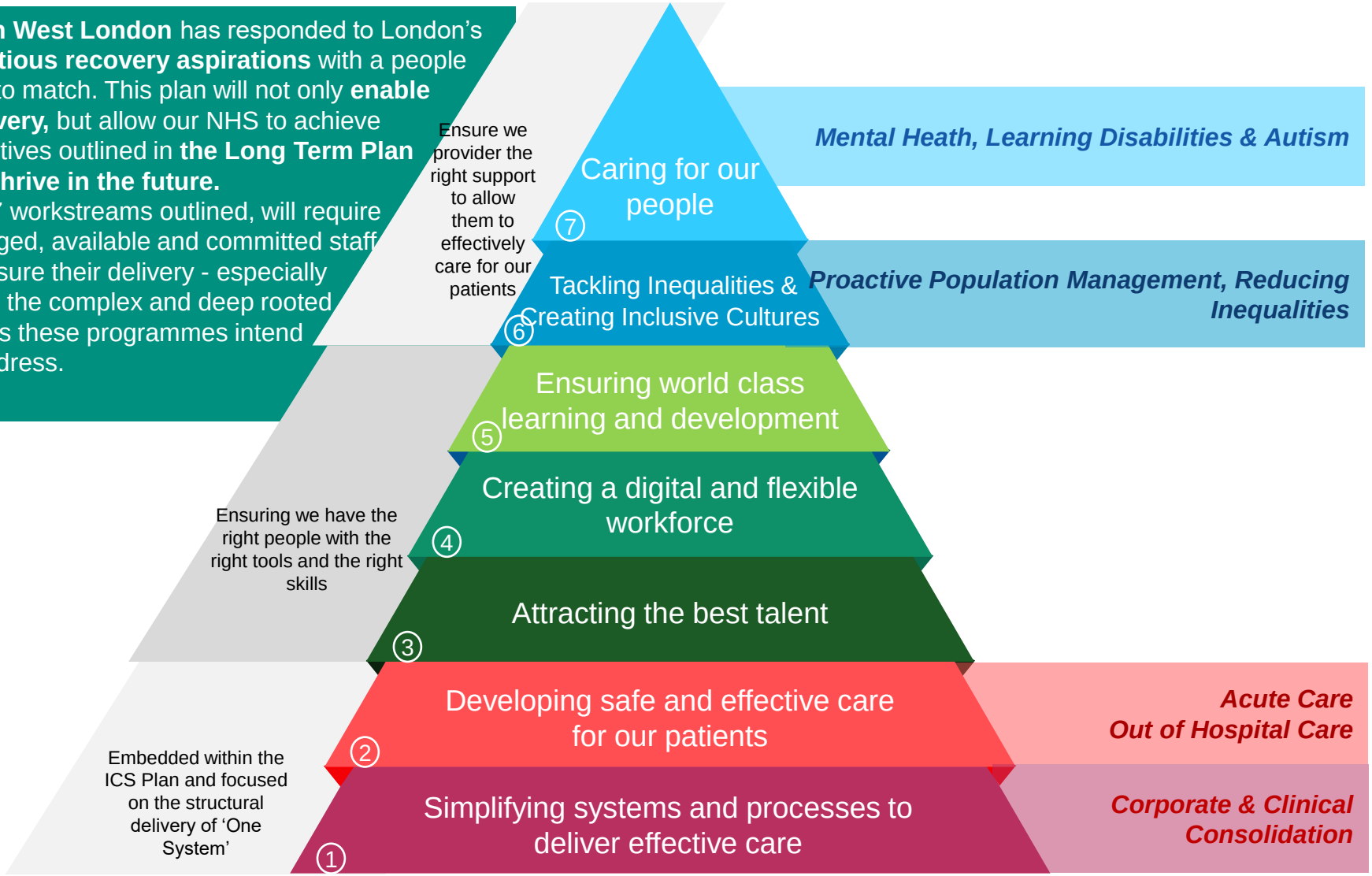
Beyond this, we plan to do more to better meet the needs of our LDA population by…

- Working differently with **local authority partners and the voluntary sector**.
- Finding **alternative models to traditional support** so that regardless of future waves of COVID-19, people will LDA and their families are supported to keep mentally and physically well.
- Building on the learning from the pandemic to **harness good practice** that emerged.
- Working with colleagues in **supported living and care homes** to provide an enhanced support offer to residents.
- Recognising the particular **needs of autistic adults without LD** who have been left largely unsupported during the pandemic.

Staff

Our NW London People Plan and alignment to the ICS ambitions

- **North West London** has responded to London's **ambitious recovery aspirations** with a people plan to match. This plan will not only **enable recovery,** but allow our NHS to achieve objectives outlined in **the Long Term Plan and thrive in the future.**
- The 7 workstreams outlined, will require engaged, available and committed staff to ensure their delivery - especially given the complex and deep rooted issues these programmes intend to address.



Further work: NW London MH Workforce Steering Group will meet on 19/06 to review the 34% increase in workforce required by the Long Term Plan

The North West London health and care partnership

For everyone

We have focused on reducing inequalities through support to vulnerable people and families, and advancing equalities within our pathways

- Ensuring access to services for patients where there has been a change in health/ help seeking behaviour as well as those who may not have accessed services due to Covid-19
- Reaching out to help communities that may not access support as well as better understanding the neighbourhoods we serve
- Ensure new digital ways of working are tailored so that our patients are not disadvantaged if they are unable to access technology
- Longer term approach to the psychological support for frontline staff and NW London wide work on BAME support

Community	• Improved access to mental health information, tools and advice including as part of community transformation, plus specific work on Complex Emotional Needs pathway to be accelerated • Mental health rehab and step down model to support people in the community • Increasing access to Talking Therapies (IAPT) and Counselling including online therapies
Crisis	• Enhanced SPA is being run with qualified clinicians, including addition of Consultant Psychiatrists from Primary Care Mental Health Services into SPA • Mental Health Emergency Centres/ hubs established to provide an alternative for some mental health patients who sometimes experience long waits in A&E • Integrated crisis offer that enables community based support and enablers patient choice
Children & Young People	• Increased access to CAMHS • Support to vulnerable children and young people and their families
Learning Disabilities & Autism	• For people with LD and autism, recognise the importance of keeping people safe when: isolation and social distancing is not possible; and/or there may be complexities around testing due to issues of consent and tolerability • Work is underway to improve access to resume annual health checks in people with LD • Service recovery planning incl. anticipating surge in demand for known patients plus prepare for any backlog in LD Eligibility & Autism Diagnostic assessment;

For everyone Supporting people with substance misuse problems, housing and employment

Substance misuse services: response to the pandemic (Opioid Substitution Therapies) in CNWL

- ✓ **Individual needs:** changes to prescribing, supervision and pick-up made on a case-by-case basis, overseen by a consultant.
- ✓ **Risk managed:** only service users deemed clinically safe were considered for a reduction in pick-up/ unsupervised consumption.
- ✓ **Safety and oversight:** CNWL Addictions introduced an array of SOPs to support services to make changes safely and to maintain clinical governance oversight.
- ✓ **Regular contact:** an assurance tracker ensured regular contact made with service users in particular those on unsupervised consumption.
- ✓ **Recovery support prioritised:** an integral element of care was the introduction of virtual recovery groups for service users across all sites.
- ✓ **Co-production:** currently compiling feedback from service users on the changes introduced to help design the 'new normal' of service provision.

Housing and Employment: Individual placement and support (IPS) services in WLT

- ❖ IPS supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer.
- ❖ West London NHS Trust and Richmond Fellowship have developed a partnership based IPS service. The service saw a total of 30 service users in 2018/19. Following successful wave 2 funding, the service is committed to supporting an additional 66 service users in 2019/20 and 75 in 2020/21. Teams at WLT are working closely with CNWL and IPS Grow, to ensure that the service is compliant with the high fidelity IPS model.
- ❖ Throughout the pandemic, the service has been open to referrals and continued to use telemedicine to work with existing caseloads despite 30% of the staff being redeployed. Redeployed staff are now returning; activity is expected to rise and the service is anticipating more referrals coming through as we move into the recovery phase.

- WLT does not provide a comparable substance misuse service, however, the **Trust is working closely with local organisations** – RISE, ARC, Turning Point and Change, Grow, Live – to jointly own a stepped care model for those with co-existing substance use and mental illness.
- **Monthly steering groups bring together clinicians from all services**, specialist agencies, mental health and substance misuse commissioners, service users and carers to develop joint protocols, deliver training and share learning.
- Post-COVID, the steering group will be used as the **vehicle to increase the offer to all residents across the three boroughs**.

For everyone

Working collaboratively with voluntary sector partners

Barnardo's in Harrow

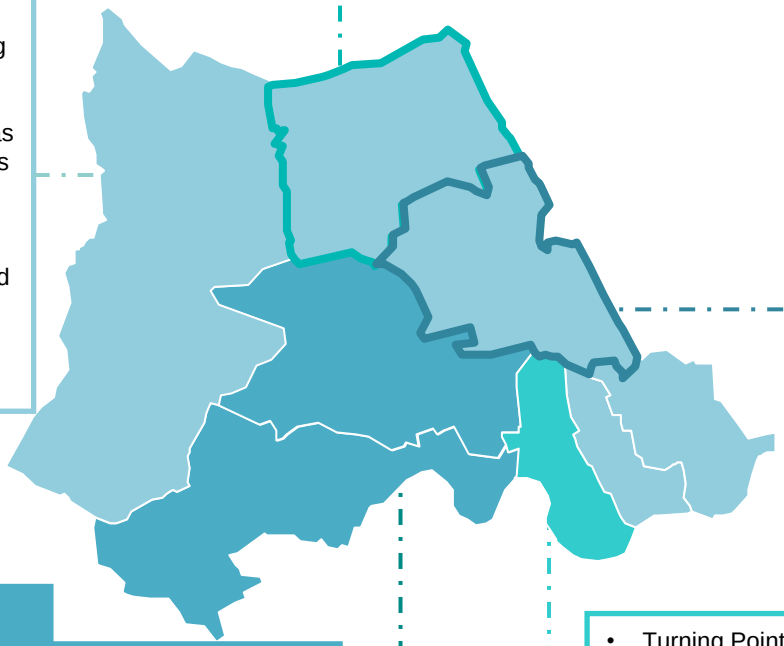
- A targeted emotional health and wellbeing service for CYP delivered throughout the community across Harrow.
- It offers a wide range of therapeutic interventions specifically addressing need at CAMHS tier 2 to tier 2.5 for CYP who do not meet the criteria for specialist CAMHS intervention.

Hestia Crisis Havens

- Hestia is providing three crisis havens called 'The Coves' in NW London
- The havens provide non-clinical support for people experiencing a crisis following assessment by the CNWL NHS Crisis Response Services. They offer a welcoming, safe and supportive space as well as a hot drink and a snack for adults (18+).
- They aim to equip people with the skills needed to reduce their immediate anxiety, formulate individual self-directed support plans and provide them with information / advice around the local services and resources that may help them moving forward.

Ashford Place in Brent

- 'Live Well, Stay Well' will support people living with a range of mental health problems in Brent with an emphasis on working with vulnerable and excluded communities including homeless/former homeless people, people living in poverty, refugees and migrants and other diverse communities.
- The service will empower and enable clients to manage mental health issues in the community – providing comprehensive packages of community-based psychological, social and welfare support



Twining's in Ealing and Hounslow

- A robust partnership with Twining's in Ealing and Hounslow will look to deliver integrated employment support with talking therapies to help residents find sustainable work in their chosen field of employment, as well as improving the quality of residents' lives and enabling them to be more independent.

Turning Point in H&F

- Turning Point works closely with all community services in H&F to provide a wide range of health and wellbeing services. Whether the person enters to the service with drug or alcohol issues, a mental health concern or a learning disability, or require individual support, the service offers a tailored approach to support the person each step of the way.

Across NW London, we are working collaboratively with partners to provide mental health support that meets the needs of our local populations. Some **good practice examples** are provided above,

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Appendix 1: National and regional expectations

There are 12 national expectations

1. A way of operationalising strict segregation of the health & care system between Covid and non-Covid and a much stricter separation between urgent and elective work especially by site, with international best-in-class infection prevention and control practices.
2. A permanent increase in critical care capacity and surge capability, centred on tertiary sites.
3. Virtual by default unless good reasons not to be: primary care, outpatients, diagnostics, self care, support services.
4. Triage/single points of access/resources and control at the front end of pathways e.g., through sector-level PTLs for all pathways prioritised by need and “talk before you walk” access to keep people safe and best cared for.
5. New community-based approaches to managing long term conditions/shielded patients.
6. New approaches to minimise hospital stay to that which is required to meet needs e.g. discharge models which maintain reductions in DTOCs/Long Length of Stay, same day emergency care, community-based rapid response.
7. Disproportionate focus and resources for those with most unequal access and outcomes.
8. Further consolidation and strengthening of specialist services.
9. A single, more resilient ICS-level platform for corporate support services and further consolidation and sharing of clinical support services.
10. New integrated workforce and volunteer models and new incentives to drive the behaviours needed to deliver these new models of care.
11. Further alignment and joining together of institutions within the ICS.
12. A new approach to consent through systematic deliberative public engagement e.g. citizens juries.

8 tests that we must meet

Meet patient needs			Address new priorities		Reset to a better health & care system		
1. Covid Treatment Infrastructure	2. Non-Covid Urgent Care	3. Elective Care	4. Public Health Burden of Pandemic Response	5. Staff and Carer Wellbeing	6. Innovation	7. Equality	8. The New Health & Care Landscape
Maintain the total system infrastructure needed to sustain readiness for future Covid demand and future pandemics	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Quantify the backlog; act now to slow growth in backlog as much as possible; develop the plan for clearing over time	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Catalogue the interventions now in place; identify additional actions now to support staff; develop the plan for recovery	Catalogue the innovations made; determine those to be retained; evaluate; plan for widespread adoption	Understand the needs of people and places who are the most impacted by inequalities and co-create models based on what matters to them	Catalogue the service and governance changes made and made more possible; deliver the new system
(e.g., capacity and surge capability in primary care, critical care, equipment, workforce, transportation, supply chain; strict segregation of health and care infrastructure; treatment innovation; role of the Nightingale)	(e.g., reductions in presentations; reduced access for cancer diagnostics and treatment; implications of screening programme hiatus; care for those with long-term conditions)	(e.g., prevention and community-based treatment, the rapid increase in 52 week waiters and the overall RTT backlog; major increase in capacity to diagnose and treat; use of independent sector for waiting list clearance)	(e.g., mental illness, domestic violence, child abuse, other safeguarding issues, lack of exercise, economic hardship; retaining the positives such as handwashing/ acceptance of vaccination, air quality, greater self care for minor conditions)	(e.g., meeting physical and psychological burden; developing a "new compact and a new normal" for support to staff in social care, primary care, community care, mental health, critical care, acute care settings; BAME staff and carers a particular priority)	(e.g., virtual primary care. outpatients, remote diagnostics, new approaches to triage, workforce models, use of volunteers, remote working, pace and urgency to decision making, financial models)	(e.g., capturing the right data to inform service design, need models of identifying and reaching out proactively to meet need; integrated health and care approaches to addressing inequalities)	(e.g., stepping up the new borough-based ICPs; domiciliary and residential care infrastructure; configuration of specialist services; governance and regulatory landscape implications; streamlined decision-making)
#1 We retained resilience to deal with on-going Covid 19 and pandemic needs	**#2 We did everything we could to minimise excess mortality and morbidity from non Covid causes**	**#3 We returned to the right level of access performance for elective cases prioritised by clinical need**	**#4 We put in place an effective response to the other effects on public health of the pandemic**	**#5 We helped our people to recover from dealing with the pandemic and established a new compact with them**	**#6 The positive innovations we made during the pandemic were retained, improved and generalised**	**#7 The new health and social care system that emerged was fundamentally better at addressing inequalities**	**#8 The new health and social care system that emerged was materially higher quality, more productive and better governed**

London's clinical priorities in mental health for COVID-19

1 Determine configuration of inpatient C19+ beds

Planning segregation between Covid and non-Covid to minimise infection prevention and control practices. Risk stratify and identify where VBD creates inequality to access.

2 Building Community Capacity

Building robust community models and linking the treatment offer to community resilience messaging. Increased capacity supported by effective partnership working through PCNs with LA and VCSO support.

3 Strengthen dedicated MH crisis pathways

MH EDs manage risks around parity of esteem with physical health needs. Robust crisis and community MH services – LTP investment.

Equality of access integral throughout each priority area

4 Access to appropriate psychological support

Creating more flexible IAPT models that can respond to distress as a normal response (beyond current IAPT models) and a diverse workforce that can support delivery through facilitated remote working.

5 Increased demand in acuity for CYP

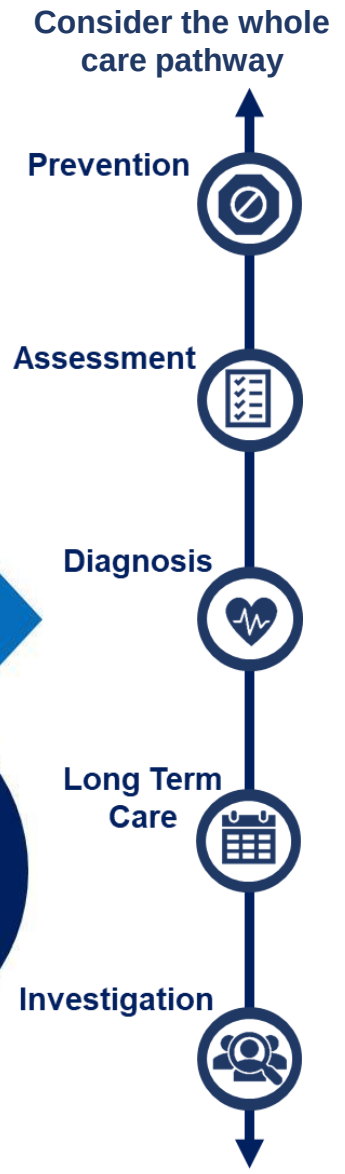
Address increasing demand and acuity in CAMHS . Ensuring the necessary support in place for partnering organisations such as schools.

6 Address increased demand in drug & alcohol

Increase in demand-in context of significant cuts in services in recent years. Mortality risks relating to disrupted care/changed consumption patterns

7 Address access to trauma services

There are limited specialist services in London. Staff trauma and wellbeing need to be supported to maintain resilient workforce.



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Appendix 2: Alignment with National guidance on second phase of COVID-19 response

NW London MHLDA priorities for recovery and reset: alignment with National guidance on second phase of COVID19 response

	Crisis	Community	CYP	LD & Autism	Supporting our staff	Enablers
Establish all-age open access crisis services and helplines (working with partners such as local authorities, voluntary and community sector and 111 services.).	✓		✓		✓	✓
For existing patients known to MH services, continue to ensure they are contacted proactively and supported.	✓	✓	✓	✓	✓	✓
Ensure that CYP continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.			✓			✓
Prepare for a possible longer-term increase in demand, including by actively recruiting in line with the NHS Long Term Plan.	✓	✓	✓	✓	✓	✓
Annual health checks for people with a learning disability should continue to be completed.				✓		✓
Ensure enhanced psychological support is available for all NHS staff who need it.					✓	✓
Take account of inequalities in access to mental health services, and in particular the needs of BAME communities.						✓
Care (Education) and Treatment Reviews should continue, using online/digital approaches.				✓		

NW London MHLDA priorities for recovery and reset: alignment with National guidance on second phase of COVID19 response

	Crisis	Community	CYP	LD & Autism	Supporting our staff	Enablers
Segregation of the health & care system between covid and non covid	✓	✓	✓	✓		
A permanent increase in care capacity and surge capability.	✓	✓	✓	✓	✓	✓
Triage/single points of access/resources and control at the front end of pathways.	✓	✓	✓		✓	✓
New community-based approaches to managing long term conditions/shielded tients.	✓	✓	✓	✓	✓	✓
Approaches to minimise hospital stay to that which is required to meet needs.	✓	✓	✓	✓		✓
focus and resources for those with most unequal access and outcomes.	✓	✓	✓	✓	✓	✓
Consolidation and strengthening of specialist services.						

The following expectations are included in the wider ICS recovery plan: single, more resilient ICS-level platform for corporate support services and further consolidation and sharing of clinical support services; new integrated workforce and volunteer models and new incentives to drive the behaviours needed to deliver these new models of care; further alignment and joining together of institutions within the ICS; and a new approach to consent through systematic deliberative public engagement e.g. citizen juries.

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Appendix 3: Mental Health Discussion Session

Mental Health Discussion Session

Draft based on MH Trust MD and ND working session 19.5.20

Overall: on the assumption of a 20-30% increase in demand across service lines or more, what is your mental health surge plan?

1. How do you plan to approach the new rules around segregation and IP&C given the challenges of the estate and the needs of patients and staff?
2. What are your plans for innovation and redesign of the urgent care pathway and for separating planned and urgent care (e.g., the concept of a mental health ED)?
3. What digital approaches will you deploy (e.g., for self management, for remote consultations, AI) and how will you prioritise patients for face-to-face contact?
4. Are there services provided by all/most providers which would benefit from greater specialisation and consolidation (e.g., paediatric care)?
5. How do you plan to make progress on addressing the worst aspects of the estate as part of your overall ICS capital plan (e.g., dormitory care in inpatient settings)?
6. How do your plans propose to meet the standard of "disproportionate focus and resources for those with most unequal access and outcomes"?
7. How will you support staff and carer recovery?
8. What new workforce models will be needed to manage increased demand for services in each care pathway?
9. Where would greater latitude versus national standards (e.g., IAPS national standards) and regulatory approaches be helpful in addressing mental health needs locally?
10. What role could pan-London collaboration play in creating the conditions for ICS success (e.g., AHSN/Cs, regional head office)?

<u>Considerations</u>

What were the population health needs prior to the pandemic?

What were the service delivery challenges pre-pandemic surge by service area?

What service delivery changes were introduced during the pandemic surge, what was their impact and what have you learned?

What new challenges does the endemic period of this outbreak create e.g. from social distancing measures to reduce transmission?

What are your service users involved in local production telling you?

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Appendix 4: North West London Mental Health Provider Collaborative

NWL Mental Health: Journey to date

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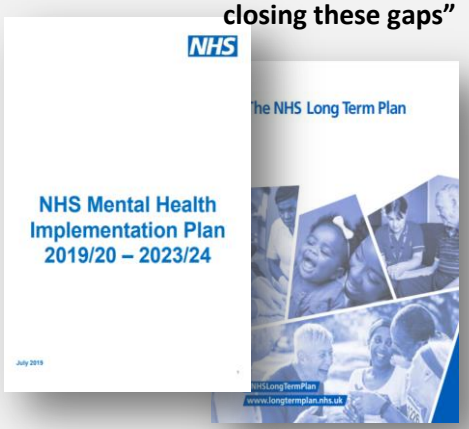
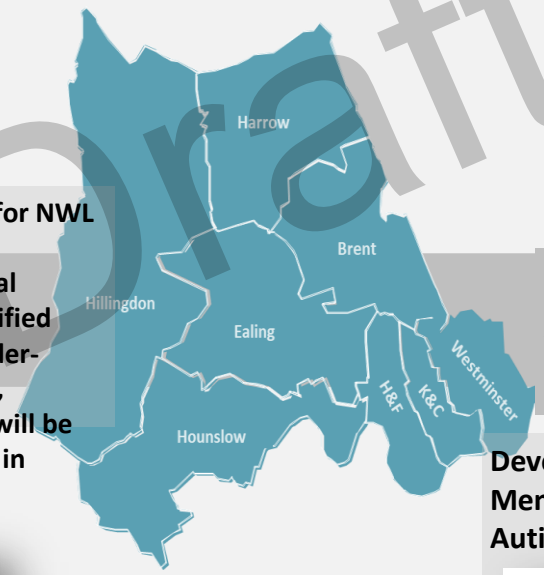
Work towards meeting MHFYFV & LTP commitments; development of provider collaboratives as part of national NMOC

Noted in principles for NWL mental health LTP submission "financial modelling has identified areas of historic under-investment; further, collaborative work will be required to support in closing these gaps"

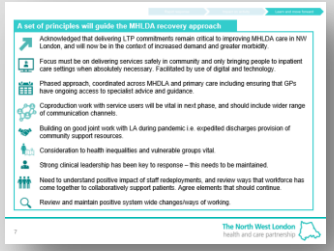


Identification with NWL of opportunities for closing gaps, and launch of ' NWL Partnership Programme' focussed on ~£178m spend outside the two blocks



NW London providers went into Covid-19 Response

Development of Covid-19 Mental Health, LD & Autism Recovery Plan



Priority now to:

1. **Deliver against the MH Recovery Plan**
2. **Deliver against the LTP Mental Health requirements**
3. **Restart and accelerate the partnership programme**
4. **Go further on provider collaboration in order to deliver these asks**

NWL Mental Health Provider Collaborative: Vision

A provider-led partnership that makes the best possible use of our collective capabilities and resources to deliver greater value; quality, access outcomes for the benefit of the populations we serve. We will enable delivery of our LTP commitments in North West London by ensuring:

1. **Greater coherence, innovation and an enriched service offer** – driven by common vision, shared outcomes and a population rather than institutional focus
2. **Patient voice** – putting the voice of our patients and their needs and priorities at the heart of our partnership
3. **A systematic focus on reducing unwarranted variation** – addressing inequalities and ensuring better outcomes for the NWL population
4. **Partnership at a local level** – developing standardised care through collaboration and coproduction, ensuring services are integrated and complementary while maintaining the identity and offer of each partner
5. **System value –** working together to make our services more productive and sustainable and investing savings into areas of key priority and need
6. **Clinical leadership and frontline ownership** – empowering our clinicians to make systematic improvements to pathways of care.

NWL Mental Health Provider Collaborative: The Case for Change

1 Quality, Service User Experience & Outcomes

- There is a marked variation in access, quality and outcomes achieved in MH services for patients across NW London dependent on the borough and neighbourhood they live in.
- The number of people with serious and long term mental health needs in NW London is double the national average.
- On average NWL men and women in contact with MH services have a life expectancy 17.5 and 14.7 years less than the rest of the NWL population this is significantly higher than similar STPs.
- Rates of emergency admissions are more than 3 times higher amongst MH service users in NWL compared to the rest of the population - 20% of all emergency admissions can be attributed to MH service users who make up 5% of the population.
- Those who experience episodes of psychosis have intense needs and account for the vast majority of mental health expenditure -nearly 90% of inpatient bed days, and 80% of spend in mental health trusts.
- Around 23,000 people in NW London have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
- High prevalence of MH disorders in CYP in NWL – 32000 children btw 5-19

2 Financial

- Potential savings by reducing mental health service acute hospital activity to the same level as rest of population (update)
- Financial sustainability - Inherent inefficiencies in the system and spending on care that does not contribute to the health and wellbeing of local people – and at the same time threatens the long-term sustainability of the local care system.
- Evidence of financial savings from existing provider collaborative which can be reinvested back into frontline services

3 System

- Fragmented approach to commissioning & contracting means that providers face different sets of incentives and constraints. Consequently, each part of the system works best to look its own interest.
- Access to MH services remain over-complicated and confusing for service users, leading to missed opportunities for the right care in the right place at the right time, uneven quality of care, and ultimately poor outcomes.
- Duplication of efforts – Current system duplicates effort, impacting on resources.
- Workforce challenges - With fragmentation, duplication, and various operational constraints comes workforce challenges. Based on current ways of working, Trusts will continue to struggle to adequately recruit and retain the workforce needed, leading to gaps in provision , lower quality, lack of continuity & unsustainable staffing costs.
- Out of area placements due to capacity challenges in parts of the system – poor outcomes and patient experience

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Appendix 5: NW London pathway changes overview and proposed future plans

*Subject to resourcing/ funding

Pathway changes overview and proposed future plans (1)

Service area	Revised Offer	Continuation of revised offer – yes/no?*	Rationale for this	What next?*
Crisis and acute care	Mental Health Emergency Centres/ Hubs with two main aims: 1. Reduce time spent inappropriately in A&E 2. Offer space to explore admission alternatives (de-escalate, HTT etc.)	Yes for minimum ~6months subject to *resourcing/ funding agreements*	• Continued support to acutes through recovery phases • Testing approach to alternative for A&E/admission (which is an LTP deliverable) • Testing support to patient flow (continuing no OAPs; fewer beds)	• High level metrics for evaluation proposed – next steps to develop into fuller WLT-CNWL evaluation framework. Evaluation approach based on maximising benefits as well as financial sustainability.
	Revised HBPoS offer: • Consolidation of HBPoS units across WLT (1 suite in H&F and 2 suites in Hounslow) • Increased/ Dedicated staffing support at HBPoS (for some where co-located	Staffing: Yes for minimum ~6months subject to *resourcing/ funding agreements*	• Long standing pan-London ask to review s.136 pathway offer & aim to staff HBPoS. • Operational requirement to consolidate suites across Ealing & Hounslow - in Hounslow 2 suites are open now (previously 1); in Ealing there was only 1 suite open to female residents from the borough (now redirected to Hounslow) . Further scope to add additional suites in Hounslow being explored through capital funding routes. • Changes have enabled view of s.136 patients who would have gone to EDs	• Data review of s.136 pathway including waits to inform immediate ask • Agree forward resourcing (revenue costs) for dedicated staffing • Set out approach for evaluation and learning of staffed HBPoS and impact of s.136 (and MHEC) pathways • Seek capital costs to build additional suites in Hounslow HBPOS Unit.
	Enhanced SPA/crisis support	Yes	• Crisis support will be required to continue, aligned to Simon Stevens letter	• Continue to run and streamline into crisis and acute care transformation
	Consolidation of inpatient sites	Yes (at least for short term, plus exploring long term options)	• Need to maintain the consolidated bed base to enable staff flex in preparation for potential new peaks • Enabler for delivery of a more community-based crisis pathway	• Explore formal processes required for future inpatient MH beds configuration across NWL • Undertake continued work to support bed flow and LOS working with wider partners, particularly in light of expected demand increased and ongoing cohorting requirements
Cognitive Impairment & Dementia Services	Memory services have been open to crisis referrals but routine referrals have been suspended during covid phase 1.	No – to reopen with capability to conduct remote appointments, thereby minimising face to face contact.	• Memory services will not be able to operate in the same way as pre-COVID-19 due to the risks inherent in face to face appointments with older vulnerable individuals • Need to re-establish offer accounting for this	Clinical Directors from both Trusts are working together to align approach and: • Model staffing numbers required to open services to all new referrals • Develop a remote working policy to conduct remote cognitive assessments either by video/ tele-consultation; and re-open groups. • Work consistently to manage change processes to enact above operationally, so that the services re-open to routine referrals on 1st July 2020

*Subject to resourcing/ funding

Pathway changes overview and proposed future plans (2)

Service area	Revised Offer	Continuation of revised offer – yes/no?*	Rationale for this	What next?*
IAPT	• IAPT services across NWL have suspended face to face appointments and offer telephone/video and computerised CBT to patients. IAPT services across NWL have continued to offer appropriate number of sessions in line with recommendations (albeit without face to face) to those on IAPT caseloads, with a particular focus on those identified most in need and further telephone support for shielding patients • WLT IAPT service has worked to achieve a reduction in waiting lists. • In addition, IAPT capacity has been used to offer additional further support via brief interventions to frontline staff/general public with Covid-19 related anxieties etc	No (in current form)	• Plan to reinstate face to face option when possible, balanced with virtual offer (in line with overall developments • Further work/resources needed to provide longer term psychological offer to staff when IAPT can no longer accommodate – i.e. when IAPT service appointments and referrals rise back to level (plus additional demand). This is a requirement from the Simon Stevens letter • WLT IAPT Services have opened to self referrals from 15 May 2020	• Specific recovery plans to ensure the services are ready for the increase in demand in the recovery phase • Recruitment in relation to expansion plans as per LTP. • Development of proposal for longer term psychological support offer to NWL staff
Co unity MH	• Focus on continued support to patients (RAG rated) and ensure safety through increased digital offer • Some teams/structures amalgamated to support volatile staffing levels • Community teams working jointly with MH inpatients and Crisis teams in terms of accelerated discharges, and some have explored 7 day working • Community based approaches in place to support shielding patients	Streamline into existing community transformation	• Some community transformation includes redesign of teams and alignment of resources incl. primary care teams – therefore service changes may already be aligned to the transformation • Virtual/digital offer protocols should be developed within this enabling appropriate use and choice for patients and support to staff to work in new ways	• Restart of LTP related community transformation to roll out innovative integrated place based models of community & primary mental health care • Review and streamline existing governance, accounting for C19 learning • Develop shared virtual working protocols across WLT-CNWL – work to include support needed to embed new ways of working with staff long term and managing increase in demand for these services.
CYP	Community CYPMH offer with increased digital delivery •	Yes with adjustments	Continued digital offer to enable patient choice and support increased access, however needs to be more balanced with a face to face offer.	Work to be streamlined into overall CAMHS transformation and rebasing of CYPMH local transformation plans
	CNWL CYP Emergency Centre + OOH crisis telephone support put in place	Yes subject to proposal	Continued need to support diversion from acute and alignment with need to enhance CYP crisis care from LTP	Exploring options for crisis hub x2 for NWL and developing joint proposal for continued delivery. This includes OOH telephone support
	Inpatient consolidation to support staffing levels and flex	No – aiming to reopen Collingham	CYP being managed at home temporarily difficult to maintain long term (particularly once usual working practice for general population resumes) and number of beds required longer term	Aim to reopen Collingham once it has been established there is enough staffing flex to enable safe reopening whilst also looking ahead to possible second spike

Pathway changes overview and proposed future plans (3)

**Subject to resourcing/ funding*

Service area	Revised Offer	Continuation of revised offer – yes/no?*	Rationale for this	What next?*
LD & Autism	Modified LD specialist community service and temporarily suspended autism diagnostic assessment	No	• Autism Diagnostic Service requires use of gold standard diagnostic tools (ADI-R & ADOS) that rely upon observations and collateral information gather. This is not possible through remote consultations at present times. This has been validated through soft consultation with other NHS led services offering similar diagnostic work. • Staffing levels improved to enable restart of these, alongside general recovery work in partnership with local authorities on LD&A offer where holistic care may have been reduced due to fluctuating staffing levels across partners	• Service recovery planning incl. anticipate surge in demand for known patients plus prepare for backlog in LD Eligibility & Autism Diagnostic assessment • Undertake rapid options appraisal for psychological support to people with LD/their families who have experienced Covid-19 related trauma and bereavement • Bespoke discussions for review of existing assessments and observations to conclude clinical opinion to replace gold standard assessments where suitable • Where needed, remote advice & consultation to non-specialist services (e.g. GP Practice) to make reasonable adjustment for PWID & Autism

Rehab	• In WLT, a number of rehab beds have been repurposed as step down beds to support acute MH inpatient bed flow.
	• For CNWL, bedded rehab work has focussed on the management of staff levels to ensure safe staffing levels despite increased sickness levels and continuation of full bed capacity.
		No	• Expected rise in placements over the past weeks
			• Rehab beds are critical to ensuring the flow and stability of all mental health beds and it is essential to ensure safe staffing levels are in place to support our patients.
			• Staffing levels are returning to normal but we need to plan to ensure rehab beds are not impacted by any potential second spike in Covid-19 cases nationally
				• Establish numbers of OOA placements as well referrals across the 8 boroughs
				• need to explore next steps for paused joint work on placements
				• For units, opening the rehab beds needs to account for managing cohorting, wider acute MH beds and placement changes in past weeks.
				• For beds still open, introducing a number of initiatives to support staff wellbeing
				  • Supporting staff who have been sick to return to their place of work
				  • Ensuring flexibility across workforce to support any areas where staffing levels are a concern