West Yorkshire and Harrogate
Health and Care Partnership
Mental Health, Learning Disabilities & Autism

MHLDA – Programme Status

Outline

We have 8 core workstreams in the MHLDA programme, supported by three enabling workstreams. This paper follows the same format as the paper presented to Committees in Common in April 2020, now reflecting on the current impact of COVID-19 and where 'business as usual' work has been able to recommence.

Below is a narrative summary of the changes. There is also a series of Annexes that provide further detail that relates to the programme:

- **Annex A** presents the narrative summary in an 'at a glance' table form.
- **Annex B** summarises the MHLDA programme 'plan on a page', in line with other WY&H programmes.
- **Annex C** presents a high-level impact assessment of the changes made to each workstream during COVID.
- **Annex D** presents the latest programme risk register

Overall Programme Governance

- The Programme Board is now **resuming** a more 'normal' focus after a couple of months primarily discussing key implications of COVID-19. This includes new areas of focus initiated during the pandemic and all mutual aid support across the collaborative to share learning and issues continues.

- The Committees in Common (23 July) is also now **resuming** a more 'normal' focus alongside continued collaboration with regard to COVID-19.

- Transformation Funding; had been paused but now **resumed**. Pending any indication from NHSE/I of wider ICS funding, it has been agreed to work based on only having access to our 19/20 carry-forward figure. Roughly £450k will be split between each workstream and has been allocated based on need/access to other funding sources.

- The Programme Team **continues** to provide more immediate support to collaborative sharing and decision making re COVID (see detail below); but is also **resuming** support for pre-existing priority workstreams detailed below.

Mental Health Delivery

Specialist Services: overall = **resuming**

- Adult Eating Disorders transfer of provider collaborative responsibilities had paused. Is now **resuming** to meet the NHSE/I go-live date of October 2020.

- CAMHS; as above NHSE/I timescales were paused. However, discussions have **continued** regarding the clinical model for the new unit, the build at St Mary's and preparation for workforce recruitment. Work to develop the business case for the lead provider collaborative is **resuming** with NHSE/I indicating an expected April 2021 go-

live date, with final business case ready in the Autumn.

- Forensics; as above NHSE/I timescales were paused. Work **continued** on governance structures and partnership agreements, with regular WY&H business continuity discussions. Work to develop the business case is being **resumed** in line with the April 2021 go-live date.

Complex Rehabilitation: overall = **resuming**

- Co-production of the service model had been paused as clinical staff were pulled back into frontline services. However, finalisation of service user engagement **continued,** and work is **resuming** to finalise the clinical model. with a focus on is not possible.

- Delivery of the capital programme depends on agreement of the model, so is now **resuming** in parallel to meet a deadline of September for the capital case to be finalised.

Secondary Care Pathways: overall = **repurposed/resuming**

- The steering group was has now **resumed** and confirmed its focus on two transformation areas: PICU and the development of community infrastructure.

- A COVID-19 weekly on crisis pathways discussions with YAS and WYP **continues**, alongside weekly discussions between the collaborative on cohorting/capacity planning for a potential Autumn/Winter second COVID-19 peak.

- Work to develop the clinical pathway for PICU is now **resuming** as an agreed priority due to the increased in demand for PICU beds and each provider experiencing an increase in out of area placements.

- Programme focus on out of area placements beyond PICU remains **paused**, with individual providers continuing local work on action plans and reporting as required to NHSE/I.

Core Performance: overall = **paused**

- Whilst NHSE/I is clear that delivery of the MHIS must continue, all non-essential reporting has remains **paused**, though we anticipate this will change (but not yet clear to what extent) following publication of the July planning guidance. In the background work **continues** to develop the MHLDA dashboard (and System Oversight and Assurance Group reporting) although at reduced priority given other requests on the ICS analytical time re COVID.

Early Intervention, LD & Autism

Adult Autism: overall = **repurposed**

- Implementation plan following the WY&H workshop **continues** to be developed in the background. However the ability to engage in awareness raising/training/green light principles within mainstream services is **paused**, as is much of the development work regarding barriers to access.

We are also conscious of the impact the COVID situation will have on already pressured waiting lists and heightened anxiety amongst the autistic population. So we have **repurposed** some work to expand access to digital resources (such as Brain in Hand).

- During COVID-19 we have also **initiated** a project with Inclusion North to help keep people with neurodiversity connected to support who would ordinarily cope outside of the pandemic period.

Improving Determinants and Prevention: overall = **continuing**

- Prevention concordat work was submitted successfully and we are now signed up as an ICS. Work in the background **continues** to consider the action plan and what services might be needed in addition post COVID.

- Work to finalise plans for the use of the Wave 3 suicide prevention funding **continues**, including final allocations to places. The WY&H suicide prevention event scheduled for June has been **paused** for **reconsideration**.

- Work has been **initiated** to provide a Grief and Loss Helpline service across WY&H for people affected by loss during the COVID period.

- Local Maternity System (LMS) support for perinatal mental health is now **resuming** and we are reviewing priorities with the LMS and Improving Population Health Programme. Development has **continued** relating to Mother & Baby Unit pathways, review of outreach services and pathways, communication and engagement work and roll-out of digital support to new fathers via DadPad.

Children & Young People: overall = **continuing**

- Work on whole pathway commissioning **continues** through the development of autism case studies via Y&H AHSN, work led by Leeds CCG on integration of early intervention and support for the OneAdoption West Yorkshire proposal.

- Planning for the WY&H CAMHS event; aspiring for zero admissions has been **paused** and will restart once CCG leads have capacity.

- Pilot work is being **initiated** to develop a joint parent/carer support & advice/crisis helpline with online chat functionality to create a night-time support service for CYP with mental health needs.

Learning Disability: overall = **resuming**

- Work to engage on the preferred model for ATU, and to develop the centre of excellence operating model is getting ready to **resume**. Operationally, weekly meetings between the units have been **initiated** and the steering group has also **resumed**. Processes are in place to continue to monitor DTOCs and inappropriate admissions

- Assessment of the current position of acute trusts in relation to the Learning Disability Improvement Standards **continues** on a slower trajectory where data is available,

but there will be a delay in receiving data as a result of COVID.

- Reasonable adjustment work alongside the Capital & Estates Programme has been **paused** for now, although alongside the wider ICS we have **initiated** conversations across the collaborative to submit capital bids linked to COVID funding.

- We **continue** to comply with Transforming Care Programme policy on Care Treatment Reviews/Care Education Treatment Reviews and supporting discharge planning.

Enablers

Comms and engagement: overall = **resuming/continuing**

- Development support on the website and monthly communications colleagues' meetings is **resuming**. We **continue** our communication bulletin for the programme, now on a fortnightly basis, including key information and shared learning.

Workforce

- Focus of the work had been repurposed onto developing MOUs between the provider collaborative; including potential redeployment requirements, supporting access to training opportunities (ie on Respiratory care and PPE use) and identifying wellbeing support.

- Work is being **initiated** in the background on options for a collaborative bank whilst a new **initiative** is undertaken to develop a consistent approach to the Prevention and Management of Violence and Aggression.

- We also **continue** to work with HEE on new placement opportunities for Psychology graduates and to sense-check workforce requirements of developing care models; particularly on CAMHS and Complex Rehabilitation.

Digital

- As a workstream we have been awaiting the output of place-based maturity assessments before pursuing further, so the strategic work is **paused**.

Psychological Support

Although it is difficult to predict demand, we expect to see an increase in psychological support needs across the West Yorkshire population over the coming months as a result of COVID 19. Some of this may be direct impact of the result of illness, experiencing grief and loss or traumatic experiences induced by the pandemic itself. Other impact will be felt as a result of wider societal changes; the loss of employment, the high profile inequality felt by BAME populations which has been amplified by the Black Lives Matter movement, the disjointed transition to school and university for many young people and people's experience of self-isolation and shielding.

We have begun conversations between the Psychology services in the collaborative, acute trust psychology services and our IAPT providers. Our focus includes developing the offer

for Severe Mental Illness within IAPT and exploring what can be done at scale to support PTSD within health and care staff, BAME communities and those who have been ill with COVID 19.

Summary and future workplan

Overall, a significant amount of our pre-COVID work is now resuming, and we continue to provide support to the collaborative because of COVID, including some new initiatives. The programme board is resuming expectations for reporting and progress, whilst recognising that capacity across all areas will continue to be stretched for some time to come.

So, what does this mean for the workplan of the Committees in Common? We need to strike a balance between existing priorities and new, COVID work. There are a number of 'new' significant items that may require a focus in the October meeting, with a return to existing priorities in January. The proposal for the rest of the financial year is:

October

- Complex Rehabilitation – for information, clinical model and capital update
- ATU – for information, update on regional operating model
- Specialised services – for information/decision on CAMHS/Forensic submissions
- PMVA – for update/decision on collaborative working
- Cohorting/surge planning – for information on proposals to manage capacity
- Psychological support – for information and proposals on collective working
- CAMHS unit – for information, build update and workforce developments

January

- PICU – for decision on collaborative model
- Specialised services – for information on CAMHS/Forensic submissions
- CAMHS unit – for information, build update and workforce developments
- Next Wave Specialised Services – for information/decision about leadership (ie Perinatal)
- PMVA – final decisions (if not taken in October)
- ATU – for information, update on regional operating model

Recommendation

Committees in Common is asked to:

- Note for information the MHLDA status update, and
- Approve the outline workplan for the October and January meetings

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Annex A – Programme Status 'at a glance'

Continuing/Initiating	Repurposing/resuming	Yet to resume/reconsidering
• Programme team to support immediate collaborative needs • Discussions re the clinical model for the new CAMHS unit and the St Mary's build • Forensics governance structures and partnership agreements • Finalising complex rehabilitation service user engagement • Collaborative discussions on cohorting and Autumn preparations • Dashboard and project metrics (to slower trajectory) • Finalising outputs of autism workshop including implementation plan • Development of MH prevention concordat action plan • Weekly collaborative crisis, cohorting and mutual aid discussions • Plans for Wave 3 suicide funding • Grief and Loss helpline • Digital perinatal support • Whole Pathway Commissioning development • Learning Disability Improvement Standards (to slower trajectory) • CTR/CeTR processes, though at reduced effectiveness • Immediate digital support ideas • Perinatal - Mother & Baby Unit data, review of outreach and pathways etc • Keeping Connected project for people with neurodiversity • Joint parent/carer and CYP advice & crisis helpline offer • Operational ATU meetings • ICS capital and estates funding submission • Fortnightly comms newsletter for MHLDA programme colleagues • Options for a collaborative bank • A consistent approach to PMVA • New placement opportunities for psychology graduates • Sense-check workforce expectations of priorities with HEE	• Programme Board meetings • Committees in Common • Transformation funding discussions • Forensics WY&H meetings and governance structures • Secondary Care Pathways steering group • Adult Eating Disorders provider collaborative transfer • CAMHS business case development • Forensics business case development • Complex Rehab clinical model and capital • PICU clinical model development • Perinatal Mental Health development work with the LMS • ATU engagement work • ATU centre of excellence clinical model • Website and monthly comms meetings	• Non PICU Out of area placement planning and prioritisation work • Assurance reporting to NHSE/I • Engagement with mainstream services re autism awareness • WY&H Suicide Prevention Event • WY&H CAMHS event planning • Capital and Estates reasonable adjustments piece • Strategic digital discussions

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Annex B – MHLDA Plan on a Page

MHLDA Programme: June 2020 'Plan on a page'

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Delivering pre-COVID priority workstreams	• Learning Disability – Closer integration of work across TCP and wider learning disability transformation agenda (reasonable adjustments, Learning Disability Improvement Standards). Delivery of the final commissioning and operating model for the ATU centre of excellence following engagement process. Continued delivery of Transforming Care Programme priorities. • Autism – Refining priorities from the March 2020 system-wide workshop, including understanding the COVID impact on waiting lists and support for service users • Secondary Care Pathways – Building on PICU modelling to work through clinical and operational pathways and a proposed collaborative approach. Reviewing community service provision, sharing learning and joint work to test and roll-out wider schemes to reduce admissions and enhanced step-down/discharge. • Improving determinants of health – Facilitate place-based local funding initiatives for Wave 3 suicide prevention funding, and system-wide schemes on real-time surveillance and training. Continued support for postvention and trailblazer schemes and development of targeted suicide prevention campaign. Understanding who is/who is not accessing perinatal mental health services and how to prioritise access for under-represented communities, including interface with regional Mother and Baby Unit. Development of actions for the MH Prevention Concordat. • Children & Young People - Supporting learning on Whole Pathway Commissioning for Children & Young People's Mental Health; holistic needs assessment with One-Adoption WY, case studies of those with neurodiversity and potential non-clinical support earlier in their lives and learning with Leeds place on earlier support and roll out of learning from the Transforming Care Programme. Supporting the development of clinical pathways and recruitment into the WY CAMHS unit. • Specialised services – completion of the Adult Eating Disorder lead provider model and final development of the business cases for CAMHS and Forensics • Complex Rehabilitation – finalising the proposed clinical/operational models and the capital business case
Delivering ongoing support and response during COVID	• Supporting effective collaboration between the NHS MHLDA providers to share learning , make collective decisions and escalate risks via weekly Crisis Pathways discussions with YAS and WYP, ATU operational meetings and Mutual Aid calls. • Secondary Care Pathways: Planning for potential autumn COVID surge and increased mental health impact of initial peak across the MHDLA collaborative • Continued operation and review of effectiveness of Keeping Connected project for people with neurodiversity and the Grief and Loss Helpline • Continued consolidation of useful communications and distribution across MHLDA partners.
Delivering new priorities as a result of COVID	• Improving joint working across the MHLDA collaborative through a review and proposal regarding the potential to standardise Prevention & Management of Violence and Aggression training. Building on this work to consider the role and operation of a Collaborative staff bank. • Identifying potential system-wide interventions for psychological support, investigating the potential offer for health and care staff, BAME communities and for those people who have experienced COVID illness. • Sharing and consolidating learning from new ways of working such as virtual consultations, and how we take this learning forward or even standardise expectations, processes and clinical models

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Annex C – Summary Impact Assessment

Workstream	**Impact on clinical effectiveness**	**Impact on patient safety**	**Impact on patient and carer experience**	**Impact on non-clinical functions**	**Impact on equality and diversity**
Specialist Services	Reduced F2F service offer = uncertain therapeutic outcomes in AED and potential impact on inpatient demand at go-live CAMHS/Forensics need time to finalise business case and understand impact	Explicit needs of AED service users taken into account re cohorting provision, capacity and sideroom usage at Newsam Centre CAMHS/Forensics need time to finalise business case and understand impact	More remote experience for AED service users outside of inpatient settings CAMHS/Forensics need time to finalise business case and understand impact	Lead provider collaborative team from each provider - capacity stretched	No obvious impact
Complex Rehabilitation	Reduced time to consider the clinical model in support of capital build, could lead to less refined model	Continued work has better understood individual needs and what future provision needs to look like to be safe	Continued work has better understood individual needs and what future provision needs to look like to suit people's needs	Reduced time to work through complexity of estates and capital options	Current out of area population diversity details known and can be utilised to develop tailored support models
Core Performance	Workstream is about reporting upwards to NHSE/I on core metrics. Expectation that these metrics cut across all categories but no specific impact as a result of NHSE/I reducing its reporting expectations for the short-term				
Secondary Care Pathways	Reduced engagement on PICU workstream may have stalled collaborative relationships in this area.	No obvious impact on patient safety as operational services remain	No obvious impact on patient and carer experience as operational services remain	Increased engagement across operational teams on crisis pathways, cohorting and mutual aid has strengthened relationships	Able to take stock of pre COVID proposals such as NAPICU guidance implications on LD cohort

Autism	Pausing of actions post workshop has meant a loss in momentum with clinical teams	No obvious impact on patient safety as operational services remain	No obvious impact on patient and carer experience as operational services remain Keeping Connected project supporting community experience of people with neurodiversity	No obvious impact on non-clinical functions	Concern that focus on waiting times will be lost in the reset phase and the workstream will need to advocate strongly for capacity to support diagnosis
Children & Young People	Some impact on speed at which clinical model developments have happened. Inability to bring all partners together so far re wider CYPMH zero admissions admission.	No obvious impact on patient safety as operational services remain	No obvious impact on patient and carer experience as operational services remain	No obvious impact on non-clinical functions	No obvious impact
Learning Disabilities	Ability to manage ATU patients more difficult due to reduced estates capacity Reduced ability to deliver on Leder with fewer staff available	Reduction in availability of seclusion suites in ATU creates potential risk to patients which is mitigated by reduced overall bed capacity	Reduction in availability of seclusion suites and complexity of service user needs putting additional pressure on ATU staff	Initial standing down of working group caused operational difficulties to cross organisational working for ATU. Since mitigated.	Disproportionate provision re seclusion for Leeds & Bradford patients currently

	Care navigator beginning to make a positive impact				
Improving Determinants	Standing down of LMS has slowed engagement re perinatal mental health Standing down of suicide prevention event is lost opportunity to reframe relationships	No obvious impact	Suicide prevention Wave 3 allocations still allocated in the same way to place to support local impact	Joint working across IPH and MHLDA has remained strong on grief and loss helpline	Continued work to identify most at need groups and generated tighter focus post COVID
Workforce	No obvious impact	No obvious impact	No obvious impact	HR directors providing mutual aid and continued support	Support given to work on workforce risk assessments for BAME staff and sharing of PPE guidance etc
Digital	As a workstream we have been awaiting the output of place-based maturity assessments before pursuing further				
Communications	Sharing of good practice has supported learning across all categories				

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Annex D – Risk Register

Workstream/Project Origin	Description	Impact	Likelihood	Total	Mitigation	Who?
In Programme	There is a relationship risk that the discussions regarding New Care Model Lead Provider status highlight unresolvable differences of opinion between senior organisational leadership across the collaborative, leading to a lack of 'one voice' and fragmented decision making	4	3	12	Chief Executives pledged to prioritise more time together. Monthly provider collaborative exec meetings to be used to surface issues.	CEOs/Keir
In Programme	There is a service delivery risk that the scale of the programme ambition and volume of possible workstreams leads to dilution and reduced delivery, leading to a lack of improvement in the areas that most need it	2	4	8	Programme structure and reporting simplified. MHLDA strategy plots what needs to happen when and in what order, supported by a more structured programme board.	Keir
In Programme	There is a relationship risk that the expectations of what the programme is here to do differ from those of NHS England regional and national teams, leading to a lack of confidence in the programme	3	3	9	Programme Director to work with NHSE colleagues to identify the 'sweet spot' between transformation and oversight. Chief Executives to support push-back as required to NHSE.	Keir
In Programme	There is a service delivery risk that individual workstreams do not have the sufficient capacity within organisations or from project teams to deliver the	3	3	9	Transformation funding from 18/19 was pre-committed, 19/20 we allocated £450 000.00 of carry forward monies and these have now been assigned.	Keir/David

	intended transformation, leading to a lack of delivery					
In Programme	There is a financial risk that the New Care Model Lead Provider negotiations with NHS England/Improvement either identify significant activity or financial risk that we cannot live with, or do not identify these risks but they materialise once commissioning responsibility sits with us, leading to significant financial and operational pressures	5	4	20	Detailed work required between all lead providers and NHSE/I, with central coordination and support through the NCM programme board and the wider programme. With decisions ultimately made by the Committee in Common which need to be sighted on all risks and mitigation proposed	Keir/NCM Leads
In Programme	There is a service delivery risk that certain priorities (such as those relating to Children & Young People) either end up being duplicated in the MHLDA programme and other programmes (i.e. CYP programme) or they fall through the gaps, leading to non-delivery on key pieces of work	2	3	6	Regular interaction between the MHLDA programme team and other programmes (particularly CYP, Maternity, Population Health, Primary Care) to agree responsibility where that is clear and to work in partnership where there are clear overlaps	Keir/Programme Managers
In Programme	There is a service delivery risk that the programme infrastructure is not sufficient to support delivery or assurance of workstreams, leading to reduced support and less effective decision making	3	2	6	We are using existing funding to support overall programme capacity	Keir

Secondary Care Pathways	There is a clinical risk that the number of out of area placements continues to grow across the ICS, leading to poorer patient experience and increased scrutiny by NHS England/Improvement. This is particulary true due to the impact of Covid.	4	5	20	Each provider is now subject to monthly monitoring from NHSE/I. Programme board in January discussing system wide approaches to reporting and secondary care pathway workshop held on 9 January to identify priority work. As a collaborative we are doing work on collective work to identify capacity ready for the autumn.	Phil Hubbard/Alix Jeavons
Community Care	There is a service delivery risk that IAPT performance across the ICS continues to fall below target, leading to poorer patient experience and increased scrutiny by NHS England/Improvement	4	4	16	Our programme team continues to work with NHS England locality team to identify and work through and support needed by local areas.	Jo/Carrie
ATU	There is a service delivery risk that increased ATU demand (and associated reduced flow as a result of delayed transfers of care) results in a requirement to utilise additional 'out of area' beds above the agreed numbers within the new model.	4	4	16	The working group is developing a single system approach to demand & flow management, and to address issues of specific longer-stay cohort and future placement & funding	Andy/Jo/Tom
ATU	There is a service delivery risk that now the changes are known that staff look to leave, particularly within the Leeds unit, destabilising the system bed base and resulting in OOA placements	5	4	20	Staff briefing being implemented to own the narrative and options being explored to retain Leeds staff in the local system	Andy/Jo/Tom
ATU	There is a service delivery risk that Increasing demand (through TCP repatriation) may result in increased admissions to ATU (at a point when we	4	4	16	A system is now in place to monitor this	Andy/Tom via Steering Group

	are reducing the bed base) resulting in either DTOCs or OOA placements					
ATU	There is service delivery risk that now the recommendation is known that staff look to leave the LYPFT ATU provision which could destabilise ATU provision lead to reduced capacity and OOA placements	5	4	20	Ensuring effective communication with staff about the future model and opportunities	ATU Service Leads
ATU	There is service delivery risk around estates developments delay at BDCFT (around development of seclusion and ability to step up to 8 beds as part of regional service) leading to OOA placements	4	4	16	Estates options being discussed at Executive Level both to support short-term capacity at LYPFT and medium/longer-term capacity at BDCFT	Andy/Liz/Dawn
CYP ADHD/ASC	There is a service delivery risk around volume of waits increasing (referrals at highest ever) resulting in long waits/delays for support	3	5	15	Each CCG currently reviewing their waits	CCG Children's Service Commissioners
CYP ADHD/ASC	There is a service delivery risk due to the Covid impact on waiting times (inability to undertake face to face assessment) resulting in longer waits and delays for support	3	5	15	Each CCG currently reviewing their waits	CCG Children's Service Commissioners