Appendix B

Report title: Mid and South Essex Adult Mental Health System – Covid-19 Reset	
Report to: Health Overview Policy and Scrutiny Committee	
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1. Purpose of the Report

1.1 The purpose of the report is to update the HOSC on the reset process within the Mid and South Essex (MSE) Adult Mental Health System. This paper is best read in conjunction with the 'EPUT – Adult Mental Health Services' paper which sets out the Adult COVID operational response during the crisis.

2. System reset response

2.1 A multi-agency stakeholders' operational group that reports to the system Mental Health (MH) Partnership Board was set up to take forward the MH reset plans. The main objectives of the group are to:

- Assess the impact of COVID19 on all mental health services, change in patients' health behaviours, new ways of working and what would be used to inform the reset plans in Phase 3 and how mental health service offers will respond to the 'new normal'
- Progress system preparedness plans for Winter and possible wave 2 COVID19;
- Define an approach and targeted initiatives to progress the work on reducing inequalities in mental health as part of the wider MSE system agenda on tackling inequalities;
- Analyse the trends of service usage and project the level of the expected surge in demand for mental health services due to:
  - **'COVID19-suppressed' demand** – deferred referrals of people who would have been referred to services had the pandemic not struck; and deferred access to care by people with pre-existing mental illnesses;
  - **'COVID19-exacerbated' demand** – increased level of service needs for some people due to deterioration of their mental health during COVID-19;
  - **'COVID19-driven' demand** – additional people needing support due to the wider impacts of the pandemic, such as self-isolation, financial insecurity, bereavement and increases in substance abuse and domestic violence.

3. Mental Health Service Delivery Changes during COVID-19

3.1 Mental health services continued to operate during Covid-19. Community MH services were open daily with minimum number of staff whilst other staff working remotely. Patients were contacted according to their care needs via telephone, video-consultation and if required Face to Face (F2F). F2F

appointments were pre-arranged, with no walk-in appointments. Nurse led clinics were held in various surgeries; where not practicable home visits are undertaken for Depot and Clozapine clinics.

3.2 The Voluntary Sector services commissioned directly by CCGs and LAs also mobilised to remote working and supported with wellbeing checks and the usual offers of support such as Befriending, Counselling, Bereavement Counselling, Advocacy etc.

3.3 The 24-7 Mental Health Crisis Response and Care service via 111 launched on 1 April 2020 with the Home Treatment teams providing a gate-keeping function. This offer was very successful in managing patients in the community and avoiding admissions

3.4 The Emergency Department Diversion service was set up to alleviate pressure on A&E departments involving the Mental Health Liaison teams. Capacity was also increased to extend the Alcohol Liaison service to provide an out of hours offer.

3.5 All MSE IAPT services switched to remote delivery via telephony, video-consult and enhanced digital offers such as SilverCloud, Dr Julian, IESO as default delivery, no service stood down. The services were engaged with national treatment specific webinars and staff trained up as per updated guidance to adapt treatment modalities for virtual delivery and also deliver C19 related interventions. Group therapies and psychoeducational groups were adapted for delivery via MS Live.

4. Re-start arrangements

4.1 At the start of lockdown there was significantly reduced activity across all mental health services especially IAPT services where a reduction of up to 60% was experienced across the system. All the services focused on managing the pre-C19 waiting lists as they supported patients to transition to remote treatment delivery. Positive feedback has been received with patients reporting good satisfaction scores with the service offers. There has been a gradual return to pre-Covid-19 activity levels and services have reported not just an increase in new demand but also significant increase in acuity of the presentations.

4.2 Mental health inpatient and community services were at 100% capacity pre-Covid-19. It is estimated that secondary care mental health surge impact will be circa. 10% which will be mitigated via the new 24-7 crisis service which will divert and gatekeep, expansion of digital solutions and the restart and implementation of the transformation projects that will strengthen the upstream service offers.

4.3 During Covid-19 the inpatient occupancy was reduced to 85% due to the need for service users to socially distance in communal spaces e.g. dining rooms and lounges. To meet the predicted surge and increased acuity:

- In-patient services may need to flex back to pre- Covid-19 100% occupancy levels where this will be safely practicable;

- There are plans in place to bring on-line, likely in Q4, extra bed capacity for Essex (covering the 3 STP/ICS'). This provide about 50% of required capacity;

- A proposal to explore purchasing Out of Area bed capacity as a region is being explored with NHS England and NHS Improvement

- MSE will work with other systems to assess whether this pressure could also be mitigated by greater co-operation across mental health providers

- Work is continuing on the length of stay and DTOC during this period as part of the MHIS developments geared towards providing greater opportunities for reducing pressure on inpatient mental health services

- As part of the regional response MSE will also examine the level of intervention with service users in advance of admission to understand whether this impacts on admission rates, capacity and flow.

4.4 IAPT services may well experience a surge in demand with impact expected from Q3. A joint commissioner and provider group is in place to oversee the return to pre-Covid-19 levels, monitoring weekly activity, sharing learning and exploring areas to collaborate on. IAPT is a high-volume service so likelihood of returning to F2F as default delivery is going to be challenging relative to productivity if Covid-19 safety measures are adhered to.

4.5 Not all Covid-19 driven demand will require clinical input therefore all localities are working with VCSEs in their networks to support those with more social needs. A significant level of sub-crisis activity will be manged via the IAPT services, VCSE service offers and the 3 MH crisis sanctuaries that are part of the 24-7 MH Crisis Response pathway ran by the voluntary sector.

5. Transformational reset

5.1 Apart from the implementation of the 24-7 MH Crisis Response and Care service all other transformation programmes were stood down to allow for staff redeployment to meet Covid-19 response. To enable delivery of the MH LTP requirements the restart will take forward the key transformation programmes which will centre on:

1. The integrated Primary and Community Care Mental Health which will define the:

    - integration of a mental health offer within the PCN;
    - wrap around wider mental health support including the Voluntary, Community and Social Enterprise Organisations (VCSEs) and social care;
    - development of a fit for purpose treatment offer for complex needs;
    - seamless management of needs between the primary care integrated offer and complex/specialist including crisis care interface.

5.2 These new models of care whilst developing at Place will be facilitated at system to ensure shared learning, quality and value for money where economies of scale are appropriate. This will enable MSE prepare to bid for the allocated national £2,055,380 SMI transformation funds later in the year.

1. Inpatients therapeutic offer and wider system MH accommodation and other community support offer will be developed through co-production to define:

   - a bespoke therapeutic offer for inpatients services to ensure patients receive treatment holistically and do not require long stays in hospital;
   - robust discharge pathways and mitigate unnecessary delays in transfer of care;
   - embedding of suicide prevention strategies as well as incorporate the learning from the recommendations of the recent Level 3 investigation;
   - better access to a mix of types of housing and greater flexibility in its use to provide an adequate supply of appropriate housing as well as non-accommodation support offers to enable patients to be discharged from hospital when they no longer need inpatient treatment.

5.3 This will aim to provide sufficient:

- Crisis housing;
- Short-term temporary accommodation for patients ready for discharge;
- Supported accommodation (including intensive support) for patients with mental health problems;
- Accommodation for patients with complex problems who may be difficult to house.

5.4 By reviewing presenting needs – including the Covid-19 related acuity, current capacity, requirements of Covid-19 infection control and social distancing, patient flow and processes will enable the development of a high standard, quality, recovery-focused service offer that will flex to meet needs and mitigate length of stay (LOS), delayed transfers of care (DTOC) and need for out of area provision (OAP).

6. Mental Health Investment Standard (MHIS)

6.1 All CCGs in Mid and South Essex are meeting the MHIS and a review and revision has been undertaken of programmes/projects for investment in 2020-21. Business cases are currently being developed for governance during September. Majority of the investment will align with implementing the transformation programmes.

7. Inequalities

7.1 The multi-stakeholder Operational group is working on various initiatives across

the system as services are resetting to deliver on the Phase 3 actions to address inequalities including specific work with BAME communities a group that had adverse health outcomes due to C Covid-19. The transition to remote treatment delivery especially for IAPT services has not benefited all patients for a variety of reasons such as not having the equipment, safe space to work with the therapists etc. To ensure inequalities to access are not inadvertently created all services are working to put plans in place to ensure patients are not adversely disadvantaged. Some of this will require support from partners like LAs.

7.2 Leads from provider and commissioner perspectives have been identified to coordinate a MH MSE approach to addressing inequalities in mental health. The work will build on existing initiatives and will involve co-production where multi-stakeholder including service users, workshops have commenced to start exploring a framework to take the development forward with clear objectives, identified outcomes and how these will be evidenced. This work will be embedded in the wider MSE inequalities work that will report into the Health and Care Partnership (HCP) Board.