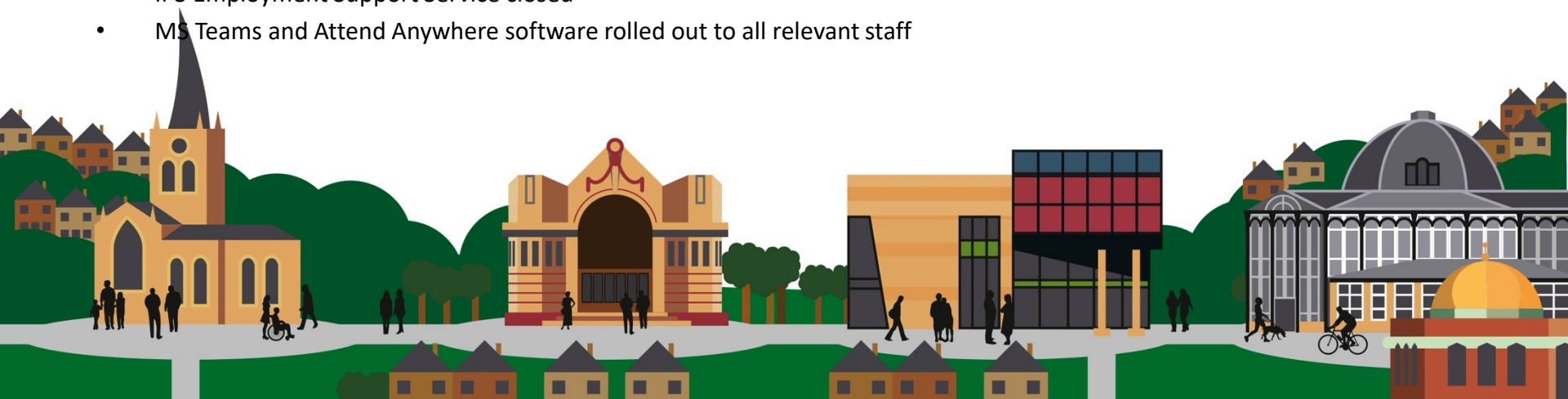
Joined Up Care Derbyshire
Mental Health

Covid Update and Future Transformation

29/09/20

Response phase – March to May

- Over 200 DHCFT staff absent for COVID-related reasons. Staff absence for all reasons over 10%.
- Additional 400 DHCFT staff in shielding or vulnerable groups, working from home.
- Telephone contacts and video contacts for vast majority of care provided
- Significant reduction in inpatient occupancy (over 100 vacant beds from higher admission threshold and rapid discharge).
- Temporary closure of Audrey House (Rehab, Kingsway) and Ward 35 (Acute, Radbourne) to prepare for potential cohorting
- Temporary closure of Childrens Neurodevelopmental Pathway by DHCFT, DCHS and UHDB.
- Significant drop in referrals across all services
- DHCFT IAPT Services closed to new referrals (other AQP providers continued services focussed on remote contacts)
- All Community Services focussed on urgent referrals and high risk patients
- Expansion of CYP Vol Sector provision and use of web-based self-help and advice tools
- Established MH, LD and Autism Helpline (9am-midnight)
- Established MH A&E alternatives in Derby and Chesterfield
- Electro-Convulsive Therapy closed due to de-prioritised anaesthetist capacity
- Memory Assessment Service closed
- Older Peoples Day Services closed across DHCFT, DCHS and Voluntary Sector
- IPS Employment Support Service closed
- MS Teams and Attend Anywhere software rolled out to all relevant staff



Restoration phase – June to Aug

- IPS Employment Support Service restored
- ECT service now operating on a case by case basis
- Referrals from all sources now increasing
- Community service focus remains on urgent and high risk patients
- Occupancy rates in inpatient acute beds rising
- Ward 35 (Acute, Radbourne) re-opened
- DCHS Ashgreen LD ATU reopened to new admissions
- Reduction in staff absence due to COVID-19
- Individual BME staff risk assessment developed with BME network and delivered across all NHS providers in Derbyshire. Identifying need for MH provision.
- Individual staff risk assessment for vulnerable and shielded groups (over 400) undertaken
- Completed Estates assessment of all clinical and non-clinical working space and made COVID secure.
- Attend Anywhere video software usage the highest across country in May.

Recovery - August to date

- Safely re-establish previous level of services across all MH, LD and Autism services whilst:
  - Providing certainty and confidence for BME, other vulnerable and shielding staff returning to work into patient facing roles.
  - Responding to emerging increases in MH prevalence and plan for evidence-based future growth in demand
  - Retaining benefits of estate utilisation, remote working, digital contacts, community and outpatient caseload risk stratification and inpatient length of stay.
  - Learning lessons from staff and patient feedback
  - Being ready to respond quickly to any second wave

Lessons learned from colleagues and people who use our services

- Qualitative surveys carried out by IMT with DHCFT colleagues and by Mental Health Together (Derbyshire Healthwatch) with their network of SMI service users and family carers across health and care.
- Colleagues told us:
  - Differing perspectives on benefits of home working: improved productivity; better work/life balance; reduced travel time and costs; lack of barrier between home and work; childcare and “home schooling”.
  - Differing views on the pros and cons of the methods of communication and directive actions taken by IMT
  - Differing experiences of redeployment: learning new skills, new teams; lack of welcome and support.
  - Different views about the benefits/ costs of current response models and desirability of retaining elements of current service models.
- Service users told us:
  - Wide range of experiences linked to how much contact individuals had had from services across health and care.
  - Positive experience correlated with individual communication early in the incident from a worker known to them.
  - MH, LD and A Helpline almost universally supported and desire to see it continue
  - Desire for more regular and reliable communication and contact.
  - Mixed views on experience/benefits of video, telephone and in-person contacts in a COVID and future context.
- Further work being carried out on the colleague survey to improve representation across services, weight the responses and look at particular issues ,like remote and home working, in more depth with focus groups.
- Current interim report from MHT being expanded with specific accessible work with people with LD and Autism to get their specific experiences of services during COVID.

Growth in MH prevalence due to COVID

- System Recovery Cell Data Workstream (CCG BI and Public Health) have reviewed the evidence for MH impact from previous pandemics, COVID and SARS in other countries and other major incidents.
- Shows that we should expect a 7.5% increase in MH prevalence from direct (trauma, bereavement) and indirect (isolation, impact of COVID-19)
- Analysis undertaken to show Derbyshire level impacts at a service level – impact included in winter plans and operational plans for 20/21.
- 7.5% does not include potential impact of economic downturn and structural change – 25% of current Derbyshire workforce estimated to be in jobs at risk. Potential for the impact of years of post-crash austerity concentrated into months.
- Need to work collaboratively across secondary care, Primary Care, IAPT providers and voluntary sector to look at joint and coordinated responses to this increase in demand

MH,LD &Autism Helpline

- Established under central direction in early April to take call pressure off 111.
- Model includes all age MH, LD and Autism
- Helpline moved to 24/7 operations from 31st July
- Service retaining the all age approach and provision for LD& Autism, but placing P3 Peer Advisors at the front door, with clinical staff sitting behind it. Model will act as a helpline support resource and also a direct access to services for people in, self-defined, crisis. Model blends current provision with our previous MH LTP
- Recovery phase will require a difficult transition to be safely managed:
  - Redeploying staff back to their substantive jobs
  - Recruiting additional staff and integrating the voluntary sector provision
  - Operating in the new model of provision from October.

MH Urgent Care activity increases (the first signs of post-COVID MH surge?)

- Significant increase in MH urgent care activity from w/c 25/5:
  - Increase in admissions to acute wards and bed occupancy
  - Acute inpatient bed capacity impacted by COVID cohorting (19 bed reduction) – patients out of area that alternatively would be in Derbyhire.
  - Increase in MH Liaison activity in CRH and UHDB
  - Increased use of s136
  - Increased use of seclusion on acute wards
  - Increased use of PICU placements
  - Estimated that around half of this recent growth is coming from people who were previously unknown to secondary care mental health services.

- Clinical review of admissions and use of seclusion found:
  - Change in acuity of admitted patients
  - Increase in Clusters 12 and 13 (psychotic illness with moderate to severe disability) and Cluster 14 (psychotic crisis)
  - Public messaging, fear of accessing services having a particular impact on this patient group resulting in them accessing services at a later and more chronic stage of their illness.
  - Risk stratified prioritisation of community caseloads may mean that people are accessing services at a later stage of their illness.

This increase in demand for MH Urgent Care services is a risk to the overall recovery plan for MH, LD and Autism

MH Urgent Care

- Vol. Sector provided alternatives to A&E for MH patients in Crisis to be established in Derby by Richmond Fellowship (October) and North Derbyshire (before winter) in line with LTP.
- Current response phase MH A&E Alternative Services to be stepped down and Liaison staff released back to previous roles.
- Recruitment into Crisis and Home Treatment Teams to continue in line with LTP.
- Above developments to link in with new model of provision from the Helpline.
- Recovery of Crisis and Home Treatment Teams through the return of redeployed staff and those colleagues from shielding and vulnerable groups.

Community Services

- Services across all ages MH, LD and Autism and across all providers have prioritised services to urgent and high risk cases involving regular risk stratification of caseloads.
- Clinical services planning for new service model retaining telephone and video contacts, but re-establishing face to face contacts where they are clinically necessary.
- This is reliant on the return to work of vulnerable and shielding colleagues and the return to substantive roles from redeployed colleagues.
- Estates and availability of clinical space is a further constraint.
- Current plans are to slowly re-establish services on a risk adjusted basis. Outline plan is to have re-established services by October, but there is a major workforce risk attached to this plan.
- DHCFT IAPT services reopened to new referrals over the Summer.
- Memory Assessment Services planning to be open from September

Community transformation

- Community mental health framework published as part of MH LTP
- Substantial and significant transformation of services
- Large scale investment - £15m in Derbyshire over 3 years starting in April
- No “tennis matches” between small teams, quicker access, integration with Primary Care Networks, wider MDTs including psychology and psychological therapies, new roles such as employment advisors, housing support workers, peer advisors.
- Prototyping new models of deliver now – High Peak started in September, Derby City in winter.

Children and Young People

- Reestablishment of CYP community services across DHCFT and CRH services as outlined in the community slide, above.
- In addition there will be a focus on establishing a 24/7 crisis response across CRH and DHCFT for CYP MH fitting in with the Helpline
- All service thresholds and referral criteria for across the CYP MH pathway, involving voluntary sector and NHS providers, to be reviewed
- Community triage established to direct referrals to the most suitable service across the pathway
- Neurodevelopmental Pathway recovery across DHCFT, DCHS and UHDB being planned, with CCG and LAs.