The Royal College of Psychiatrists

Better Data, Better Care: what data tells us about mental health services during COVID-19

Thursday 17 September 4-5pm

#RCPsychLive @rcpsych @rcpsychGAP @rcpsychCCQI
Stephen Watkins
Director, NHS Benchmarking Network
Quantifying the impact of Covid-19 on UK Mental Health Services

Royal College of Psychiatrists General Adult Faculty Briefing

17th September 2020

Stephen Watkins, Director, NHS Benchmarking Network
Overview

- Impact of Covid-19 on NHS mental health services
  - Inpatient trends
  - Community trends
  - Adult Mental Health – community demand and activity
  - Next steps

- Discussion points
Project background

- Monthly collection commencing with April 2020 data
- Measuring impact of COVID-19 on Mental Health and Learning Disability services
  - Includes IAPT, CAMHS, MH and LD
- Different emphasis from national SITREP
  - Explores impact on normal business
- Time series analysis explores the changes that Covid has created in demand and activity. Areas explored include;
  - Bed numbers and occupancy
  - Admission and discharge patterns
  - Number of referrals and acceptance rates to community services
  - Changes in access (e.g. source of referral)
  - Different ways of delivering care including the digital response – contact rates, non-face to face activity including those via video
Inpatient care – adult acute care

- After an initial dip in late March and April (-6%), adult acute bed numbers are returning to pre-Covid levels (-4% by July 2020)
Inpatient care – adult acute

- Adult acute bed occupancy rate displays a month on month increase from a low point of circa 70% at end of March, reaching 90% by July
Inpatient care – bed occupancy

In almost all bed types, the largest declines in bed occupancy rates were seen in April, before occupancy rates began to increase in May-July. The majority of teams are now moving towards a return to previous levels, as shown by the red dots on the chart.
Inpatient care – use of the Mental Health Act

Mental Health Act use at point of admission has increased in all specialties

National position: Proportion of admissions under the Mental Health Act in month (patient detained at the point of admission)
Referral volumes are reduced, and referral sources demonstrate a different mix as changes in sources of referrals have been reported:

- **Primary Care** referrals to Adult CMHTs reduced from 41% to 25% in April, before climbing to 38% in July

- For CAMHS the reduction was from 45% to 28% in April. By July, this had risen to 35%

- **Self-referrals** and those from carers to Adult CMHTs increased from 7% to 12% in April before returning to 2019 levels by June

- The proportion of self/carer referrals to CAMHS remained fairly consistent from 2019 levels of 7%, compared to 9% in July 2020
Community teams - referrals received

- Referrals to community mental health teams fell by 43% nationally in April. Whilst referral numbers are now growing, referral levels are still 10% below pre-Covid levels.
- Referral acceptance rates to adult community mental health services are marginally higher than historic 2019 levels.
Referrals to Crisis Teams fell 27% in April, but have moved towards 2019 levels by June/July.
There has been a significant shift away from face to face contacts. Non face to face care is now the most common medium of activity; Adult CMHTs = 59% of contacts non-face to face, CRHTs = 43% non-face to face CAMHS = 75% non-face to face
Community teams – non-face to face contacts

- In 2019, most providers delivered a third (or less) of their contacts in a non-F2F format
- April 2020: 68%
- Reduced to 59% by July – reassuring shift for services where face to face contacts may be preferable
- 50% of CMHT patients had a clinical contact in July
Although a notable proportion of contacts are now delivered in a non-face to face manner, digital technologies are still embedding. Their use is most wide-spread within CAMHS, where 22% of all contacts delivered in July 2020 involved digital technologies such as video conferencing.

IAPT and Learning Disabilities services, particularly for children, have also shown good uptake.
• On average 3% of contacts delivered in April nationally were via video link, increasing to 5% in July
• Variation in adoption nationally where usage ranges from 1% to 21%
Nationally, caseload numbers reduced by 11% in April.

Whilst caseload numbers rose in June indicating a possible recovery, by July they fell to 12% below 2019 rates.
Community teams - contacts

- In contrast, contact rates have continued to recover well following a drop in the first months of lockdown.
- July: 1% below 2019 reported figures.
Next Steps

• Continued rapid turnaround of data with monthly bespoke reports issued to all participants. August report to be issued next week

• Online dashboard/toolkit containing wider range of specification metrics now available to participants

• Ongoing collections each month

• Virtual Exec Team / Board briefings welcomed
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Simon Rose
Lived Experience Educator,
Derbyshire Healthcare NHS Foundation Trust
Real life impact: the information contained in the data

A challenge for commissioners, clinicians and wider healthcare systems

Simon Rose LL.B (Hons), PG Cert (Med Ed), FHEA
Lived Experience Educator, Derbyshire Healthcare NHS FT
Hon Clinical Teacher, Academic Unit of Medical Education, University of Sheffield
Patient Representative on Council, Royal College of Psychiatrists
We have heard…

Community Mental Health Teams:
- Referrals
- Face to face contact with people receiving care
- Digital/on-line contact

In-patient Settings:
- Bed numbers, bed occupancy rates, admission rates
- Detention rates
In my experience (based on 25 plus years of receiving care from mental health services), interactions between clinicians working in mental health and their patients are rarely neutral:

They have the capacity to be therapeutic and thereby a positive impact on patient’s mental health

or

They have the capacity to be a negative experience and to have a detrimental impact on patient’s mental health
Ten people

Impact of decreasing referrals/harder to access services?

‘Received an appointment for the ‘emergency appointment’ nearly 3 months later. I was left [in the meantime] with absolutely no support’

‘I’ve made 3 attempts on my life in the past few weeks and literally no-one is listening… To note, I am currently safe but wanted to give you my honest experience’ - M
I'm not under the CMHT. They basically only accept referrals if somebody is at serious risk of immediate harm and I wasn't. We have an intermediary service but they suspended all routine referrals. GP brilliant thank goodness! That said I would have really struggled to communicate with her over the phone if we hadn't already had an established relationship’ – S

‘It is really shit. I looked at private help. I earn a decent wage and still couldn't afford it. If I was on a low income or unemployed I could have got help. I asked my rape crisis centre for help. They closed their waiting lists as they were so long. I was pro active in trying to get help. There isn't anything out there. A lady from Victim Support has been my saviour. She is the only constant I have had in all of this.’ - A
Impact of increasing digital contact – decreasing face to face contact

Paranoia

• I was unwell and paranoid but my CPA meeting took place by video call. I didn’t want to log into the Trust system. Then nobody could get in the room for 40 minutes – G
• Not as effective as face to face

• 'I had said appt recently and it was a video call. This meant that the obvious clues that I wasn't coping were missed, and I simply wasn't listened to. My MH symptoms were ignored and they made it clear that they were not going to anything other than talk about my physical health. I became completely overwhelmed by intrusive flashbacks and noise and left the meeting in complete acopia, completely consumed by the "goblins" - no-one has bothered to check that I was ok/safe - I was not’ - M
• I’m utterly destroyed by how mental health services have and continue to be during the pandemic. I had a huge life changing situation happen that I don’t want to share, but it meant plunged into living alone after 20 years of being with my husband. I feel lockdown is so traumatising to remember I push it the same way I do with triggers of my PTSD. It’s fear of remembering the loneliness and absolute loss of support in the way it was. I don’t agree that services stopped and continue to stop being face to face.

• Why is my mental health care taken away. Put on to SKYPE. I feel alone and ill. I’ve ended up having hospital admissions, been in A&E, been in a crisis house, been under CMHT crisis team. I didn’t need to get to that point. My anorexic behaviour has crept in, my OCD is crippling. I don’t think it’s rocket science why!’ - K
Lack of privacy around appointments

• ‘Hmmm no I would say it was more awkward at home. For context I lived with parents over lockdown. Compared to at uni, I am with flatmates who know everything. I wouldn’t tell my parents everything out of fear of worrying them. And so for therapy each week I would go into the garage in my garden to gain a sense of privacy’ – N

• ‘Personally, I have found phone contact very difficult. I have to leave the house and park up somewhere in my car to receive phone calls, whether it be from care coordinator or psychologist. I ask them for a time when they will and they are so vague. And so for therapy each week I would leave the house to go to somewhere else to gain some privacy however, that was never as comfortable as it would have been to have therapy in my own familiar room.’ - A
In-patient care

- Feb 20 – S returns home from university, unwell
- 14th March – returns to university
- 15th March – housemates ring – S is ‘in a state’
- 16th March – assessment and informal admission
- 20th March – attempt absconsion – section 2
- 28th March – transfer to PICU
- 31st March – no longer needs to be here
- 1st April – S brought out to car park with belongings and meds; no referral done to home Trust, no care plan
- 2nd April – Difficulties transferring notes to home Trust
- 3rd April – Home Trust only taking referrals from GPs
- 4th April – rang crisis line – go to A and E – admitted via police van after parents engag the Trust CEO on Twitter!
• ‘I will add that we have had really good care from [home hospital trust] over the years, and when S was in crisis [community services from ‘at university’ hospital trust] were very helpful.’

• I am convinced he was discharged from [at university Trust , due to covid reasons. He is now stable and back [at university]. I just hope he keeps up his meds.’ – G and M, talking about S, their son
Lessons

- Difficult to balance staff safety v patient safety v covid risk v mental health risks

- However:

  - Interactions between services and patients are not neutral in mental health. Causes something to happen…
  - May be that the only people who came to talk to me are the people that don’t like the ‘brave new, covid-world’
  - However, in a world where people are entitled to person centred care, we must do better. Getting it wrong can cause harm.
Thank you

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Dr Asif Bachlani

Clinical Director for Acute & PICU Network, Priory Group
WHY DATA MATTERS

Dr Asif Bachlani

17th September 2020
Data and Clinicians

+ Getting to know your service
+ Identifying aspects of service that need to improve
+ Using data to back up your view
+ Developing Kingston PD Pathway
KNOW YOUR SERVICE

What the service gap?
Current PD interventions in N&S RST’s

1-1 Psychological therapy

Psychodynamic Psychotherapy

STEPPS/STAIRWAYS

EUPD Interventions

Outpatient appointments

“Joint” working with private sector, other organisations

Care co-ordination

Combination of 1-1 work and skills groups

SUN
WHAT'S THE PROBLEM

Gathering the evidence
Inpatient Bed Days – Cluster 8
2016/17

Nationally inpatient bed utilisation for Severe PD was up from 5.9% to 6.4%

Cluster 8 bed days: SWLSTG > Oxleas > SLAM
National Data - Adult acute beds per 100,000 weighted population (16-64)

- Mean average bed provision of 19.5 adult acute beds per 100,000 registered population
- London mean average = 19

- Beds: Oxleas > SLAM > SWLSTG
### Bed days for Cluster 8 – per borough

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<th>May</th>
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<th>July</th>
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### Bed days (inc leave) : All non-cluster 8

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KINGSTON PD PATHWAY

Setting up a new ‘service’
KPDP Steering Group

- Co-Chairs – Malcolm Simpson + Asif Bachlani
- Acute: Hannah Jones / Zul Ahmad
- KRAT: Margareta Posse
- Psychology: Siobhan Woollett / Anna Iwnicki
- Psychotherapy: Anthony Ang
- Operational: Rick Dalton / Paul Moorey
- OT: Sally French, Cath (Richmond)
- RSTs: Mandy Khan, Ann Plummer, Dave Emmett, Esther Taj, Maria Alonso, Sara Beleil
**Principles**

- Recovery focused and promote self-management
- Time-limited, clearly defined treatment pathway
- Outcomes based
- Positive risk management
- Facilitated discharge at end of treatment ‘graduation’
- Remodel workforce to meet patients’ need
- Appropriately trained WF
Proposed Care Pathway

- Referral
- Triage
- RST Formulation
- Psychological Work
- Pre-discharge & D/c to GP
- SCM STEPPS
- DBT/MBT
- Psychotherapy

GP HTT Ward
K&RA T
CCO or Nurse Therapist
Nurse Therapist
Nurse Therapist Psychologist
KPDP Proposal to Commissioners

Model 1 - Specialist DBT treatment team
• Delivers DBT and Caseload capacity is 35.
• Cost = 254k

Model 2 - Enhanced PD treatment pathway
• Offers choice of either DBT or SCM alongside assessment within RSTs + dedicated GP liaison.
• Caseload capacity is 40 with Cost = £285k

Commissioners—fund 180k from April 19
TOP TIPS
What can I do as clinical leader
Invest in one’s work relationships
Having a ‘moan’

sorry = constructive chat
“Improvement in healthcare is 20% technical and 80% human”
Marjorie Godfrey (The Dartmouth Institute).

- Stakeholders
- Co-production
- Perceived benefits
- Perceived workload
- Top down
- Bottom up

Change is threatening
“Its always been done this way”
Work with patients

**Coproduction**

Best understanding of:
- My own needs
- My preferences
- My own resources
- My networks & community

Expertise in:
- Needs, causes & evidence
- Assessment or diagnosis
- Services & treatments
- Systems & entitlements
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