

Post - Covid '19 Mental Health Clinical Board Recovery Plan & 2020/21 - Brief IMTP

June 8

2020

As the Impact of the Covid 19 virus recedes Mental Health services are finding themselves at the forefront of a surge in demand for services – this document describes the preparations and changes the MHCB and its partners are making

**Covid Recovery and Continuity Plan
Version 4 – 8th June 2020**

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1. Context & Background

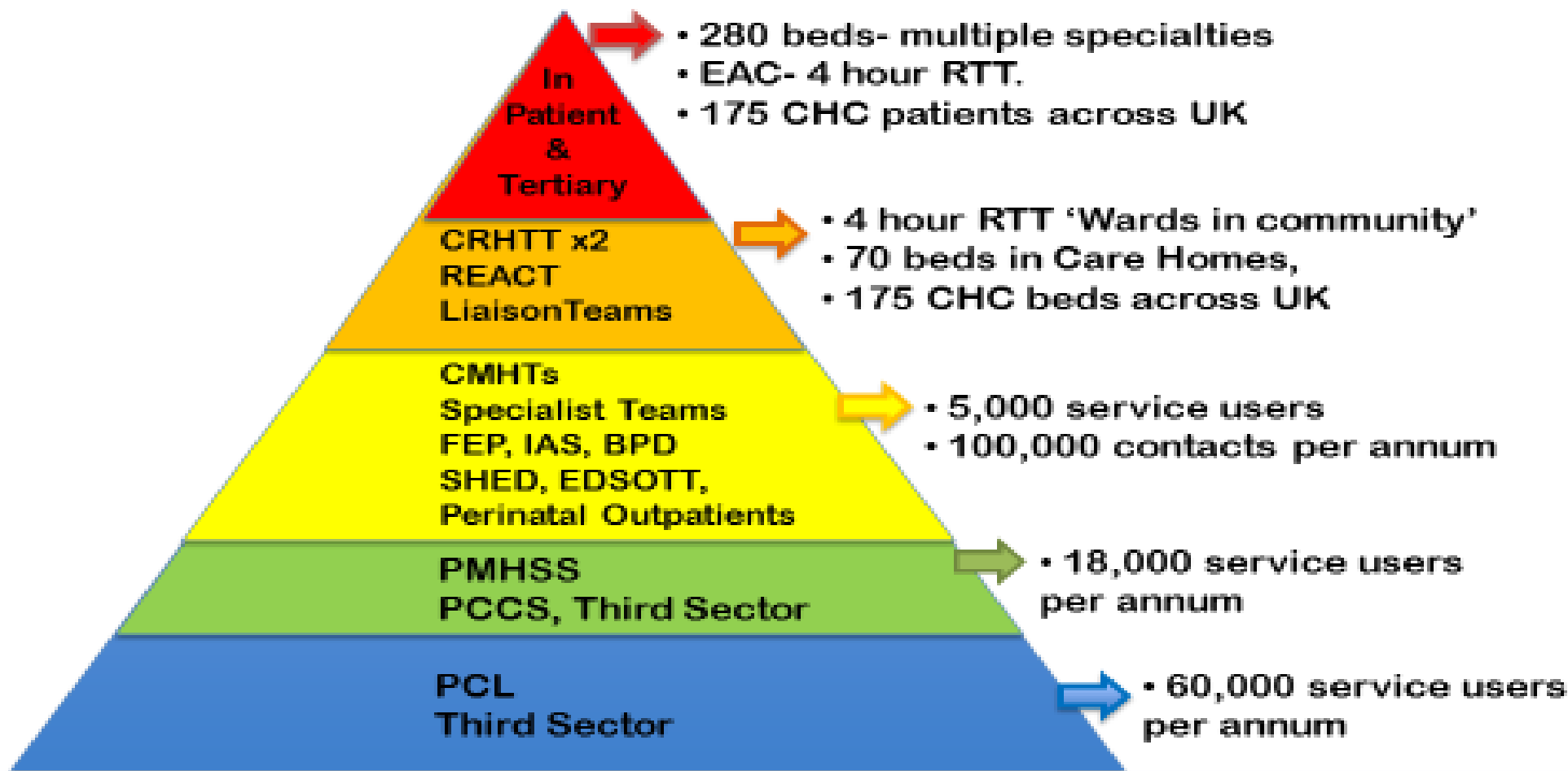
This document provides a suggested framework for the preparation of a C&V recovery/continuity plan for mental health and substance misuse for adults. This document will also be the basis of a consultation document with the Service Users and Carers within Cardiff and Vale and the Community Health Council in the coming months.

The plan will be informed by service user engagement/feedback and available research including from other countries and bespoke studies. The plan will need to be updated and adapted as the situation progresses.

It is suggested that the recovery plan consider the follow matters:

- ✚ How and when to begin transition from a Covid 19 state for services towards a new normal operation - recognising further Covid 19 peaks and associated lockdowns may be required and it might be necessary for service to flex their operating arrangements accordingly.
- ✚ The stages of recovery, from immediate actions to reinstatement of some services or repurposing staff to considering the medium and longer term
- ✚ Identifying changes (particularly innovative and or transformational) made to services during the Covid 19 crisis that should remain and how we establish whether some service models can/should be adopted quickly on an all-Wales basis and gain a consensus for doing so.
- ✚ The need to undertake demand and capacity planning which takes account of likely additional pressures on services resulting from the scaling back of services to existing service users, as well as forecasting and stratifying additional demand created as a result of the impact of the Covid 19 crisis on both previous mental health service users and the wider population. It will be important to recognise that an future surge in demand is likely to be problems with 'wellbeing' rather than mental illness per say. Therefore the importance of partnership working with service users and the third sector is of vital importance.
- ✚ Identifying available supporting information from a rapid review of the evidence, research and surveys to assist planning (e.g. from previous civil "emergencies").
- ✚ Possible solutions to allow current models to meet the likely demand for additional services – including retaining and enhancing general population approaches and self-help options

Cardiff and Vale Mental Health Services



250,000 contacts per annum



The strategic recovery plan will be supplemented by


- ✚ The development of service-specific plans (e.g. perinatal, BPD, FEP) setting out detailed priorities, considerations and issues
- ✚ Identification of the risks to the delivery of plan and mitigating actions
- ✚ Gathering lessons learnt to inform future emergency/pandemic planning.

2. Supporting/linked work being undertaken

- ✚ Welsh Government will be undertaking a review of the Together for Mental Health 2019-22 delivery plan priorities and timescales in the light of Covid 19. The Mental Health Network and respective subgroups will also review planned work streams to assess alignment and where their work can support or be informed by the recovery plan over the next 6-12 months.
- ✚ The Welsh Government are sponsoring national research across all UHBs into the patterns of Mental Illness presentation over the coming 1-3years. This research will provide the UHB with real time updates for strategic decision making, be hosted by ABUHB and seek ethical approval via Swansea University.
- ✚ Welsh Government to undertake a review of post pandemic and disaster literature on Mental Illness presentation for distribution to local services
- ✚ The Covid 19 Mental Health co-ordination arrangements have supported the identification, validation, preparation and publishing of a range of population mental health and wellbeing resources and on line support packages. It is intended that this work will continue to be developed in partnership with Public Health Wales and adapted for longer term use where needed to support this recovery plan.
- ✚ A range of reviews and surveys are already underway and more are planned to assess the mental wellbeing of the general population and of existing mental health service users. It is proposed that some surveys ask more direct questions about the type of support and help needed.
- ✚ There is a regular cycle of remote engagement with Service Users/Carers and the 3rd sector

3. Principles and Ethical/Equality Framework

- ✚ All decisions patient centred
- ✚ Simplify Access
- ✚ Equity
- ✚ Dispersal of Resources
- ✚ Maintain all services albeit pared back
- ✚ Don't re-start anything without good evidence

 All actions will be subject to EHQIA

4. Recovery Timetable

Action to recover services will need to take place in a number of phases and it may be necessary to regroup or pull back arrangements in response to the future pattern of the pandemic. This plan cannot therefore set a precise timetable but aims to give a guide to run alongside the lock-down and social distancing requirements and pandemic conditions. It will need to take account of modelling on Covid 19 infections being undertaken separately. It will also need to take account of other NHS wide service-wide changes in guidance such as on use of PPE and relaxation of visiting and leave restrictions.

The aim should be to bring services back on stream services and build capacity to cope with demand as quickly as it is safe to do so. However, the recovery plan it should provide the opportunity to assess the impact of some changes to services to enable a considered decision on whether some innovations/changes should be retained. Recovery actions could be considered in the following illustrative phases aligned with lockdown/social distancing restrictions and other conditions. It may be necessary to collapse/merge some phases according to local conditions. Although timescales/phases will ultimately need to follow the nationally determined phasing/traffic light system of recovery, the following indicative phases and timeframes may allow us to develop options for planning purposes.

Service User / Carer Comments	Recommendation
<p><i>One of the most difficult issues to embrace during Covid-19 is uncertainty. Media speculation leads to the expectation that we, as an advanced, evolved and mature society, believe we can control events. Management of uncertainty is difficult because it also involves managing expectations and disappointment. Living with poor mental health frequently means living with uncertainty. Disappointment does not kill people but neglect does so keep</i></p>	<p><i>A recommendation if possible in this context, make it clear that MH workers have, personally, felt the impact of the pandemic and this informs mental health service delivery. Make this threat an opportunity. If you are serious about involving service users in planning service delivery draw on the experiences of service users on your staff. They are not weakened by their experiences but are more powerful advocates for positive change.</i></p> <p><i>Contextualise breakdowns in service delivery over this recent period e.g. illustrating staff shortages due to illness/lockdown/bereavement/absence of transport/lack of tech competence or equipment for virtual meetings on the part of service users or staff. Draw on this knowledge and write these probabilities into future responses</i></p> <p><i>Contextualise potential spikes or second waves of the virus with this info. Tell us what you intend to do based on what has happened so far, and note both experience gained that may alleviate uncertainty in later stages. As we learn to deal with this pandemic we will apply our experience if it recurs in whatever form.</i></p> <p><i>Consider the positive outcomes of social distancing within different MH conditions, explore how this works differently for individuals. Gather data for research and better understanding of conditions and management of them. Also explore responses to mask wearing, how does that impact on service user engagement in a therapeutic setting. How has it affected interpretation of service user responses in therapeutic settings or triggers for psychotic episodes or</i></p>

<i>us informed.</i>	<i>sense of protection or isolation etc.</i>
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PROPOSED PHASES

- A. Immediate Covid Response - Soon after the confirmed disease peak (but within lock down and strict social distancing constraints) – now
- B. Short Period Following some limited relaxation of lock down but with strict social distancing continuing (1-2 months: May – End of June 2020)
- C. Some further relaxation of lock down but social distancing continuing (3-6 months: July – Dec 2020)
- D. Ending of lock down and some social distancing measures relaxed (6-9 months: Jan 21 Onwards)
- E. post vaccine availability – longer term (post 9 months: 2021 New Financial Year)

A	<u>Soon after the confirmed disease peak (but within lock down and strict social distancing constraints) - now</u>
Public Protection constraints / UHB Arrangements	Actions to Date
Move from CB Structure to Site Management Structure and PCIC – Site HUBs for UHW, UHL, PCIC and DHH- MH Feeding into UHL, PCIC and DHH	<ul style="list-style-type: none"> • MHCb to constitute new CB structure to meet twice weekly • Interviews for Deputy CBD and CD posts • Arrange representation on HUB and site meetings • Developed Medical pathway documents to ‘consume own smoke’ within MH – training provided for MH staff and access to medical support arranged • MHSOC Rota and 7 day Senior clinical nurse cover rota arranged • Separate Junior medical rota completed
Lock down and strict social distancing constraints continue – service saw in the first 10 days of the outbreak at the beginning of April staff losses of over 200 WTEs, cases on MHSOP wards increase to 25 in	<p>Looking at all emergency changes put in place to cope with surge in acute physical care needs to identify if staff should be re-deployed to meet possible changes in demand at the front end of pathways:</p> <p>Adult</p> <ul style="list-style-type: none"> • Covid Positive and Step Up/down wards established in Hafan Y Coed: PINE (11 beds) emptied of elective DTOX unit. Ward prepared and Staff team recruited and trained. Maximum of 3 CV19 patients seen on the 11 beds. • Community Staff moved to support inpatient services in a phased way: In Community services to respond to the staff losses and potential spread

<p>the first week, and the dissolution of the CB structures for site hubs.</p>	<p>of the virus, all emergency referrals centralised to the crisis teams in HYC, all urgent referrals centralised to the three locality bases and routine work undertaken from the CMHT bases. Community caseloads RAG rated for complexity and risk using an RCP tool and resources allocated accordingly. Clozapine and Depot clinics moved to appointment system. Most routine work undertaken by phone, all emergency and urgent work undertaken face to face with PPE.</p> <ul style="list-style-type: none"> • Use of Digital tech for patient contact commenced: Skype and Attend Anywhere with investment in training and equipment. • Day Hospitals Closed • Community Rehab/FORT team redeployed to CRHTT work <p>MHSOP</p> <ul style="list-style-type: none"> • 4 covid wards prepared: East 10/12 for covid positive – immobile and mobile patients respectively • East 14 established as male step down and East 16 as female step down – isolation areas established on each ward where needed. Rotas re-written regularly – additional skills training for use of syringe pump, IV and Oxygen therapy. • REACT CRHTT and CMHTs merged flexibly • Day Hospitals Closed • First Episode Psychosis <p>P&PT</p> <ul style="list-style-type: none"> • Primary Care Liaison: Consolidated both at Global Link and through Home working – moved to cover all clusters and meeting all demand from PC via phone and digital platforms – significant anxiety/depression/domestic abuse/frustration seen • PMHSS and Primary Care Counselling: Merged into a SPOE to avoid queue system for counselling. Managing demand from core team based at Hamadryad and Home working – all work undertaken by phone • The IAS have kept one office for staff to access as needed for printing of reports, letters, making confidential telephone calls etc. the rest of the IAS offices and consultations rooms etc. are being used by other services; Headroom, Midwives and tethering PC's for PC Liaison service. • Veterans NHS Wales • Therapy being delivered successfully via Skype. • Dragon's Heart Hospital • Work continuing to provide a psychological support hub for DHH. Further clarification from UHB Executives requirements needed. Possible requirement for other disciplines to join the employee wellbeing hub. Some discussions held regarding input from Liaison Psychiatry that require further dialogue with the Adult Directorate and the MH Clinical Board.
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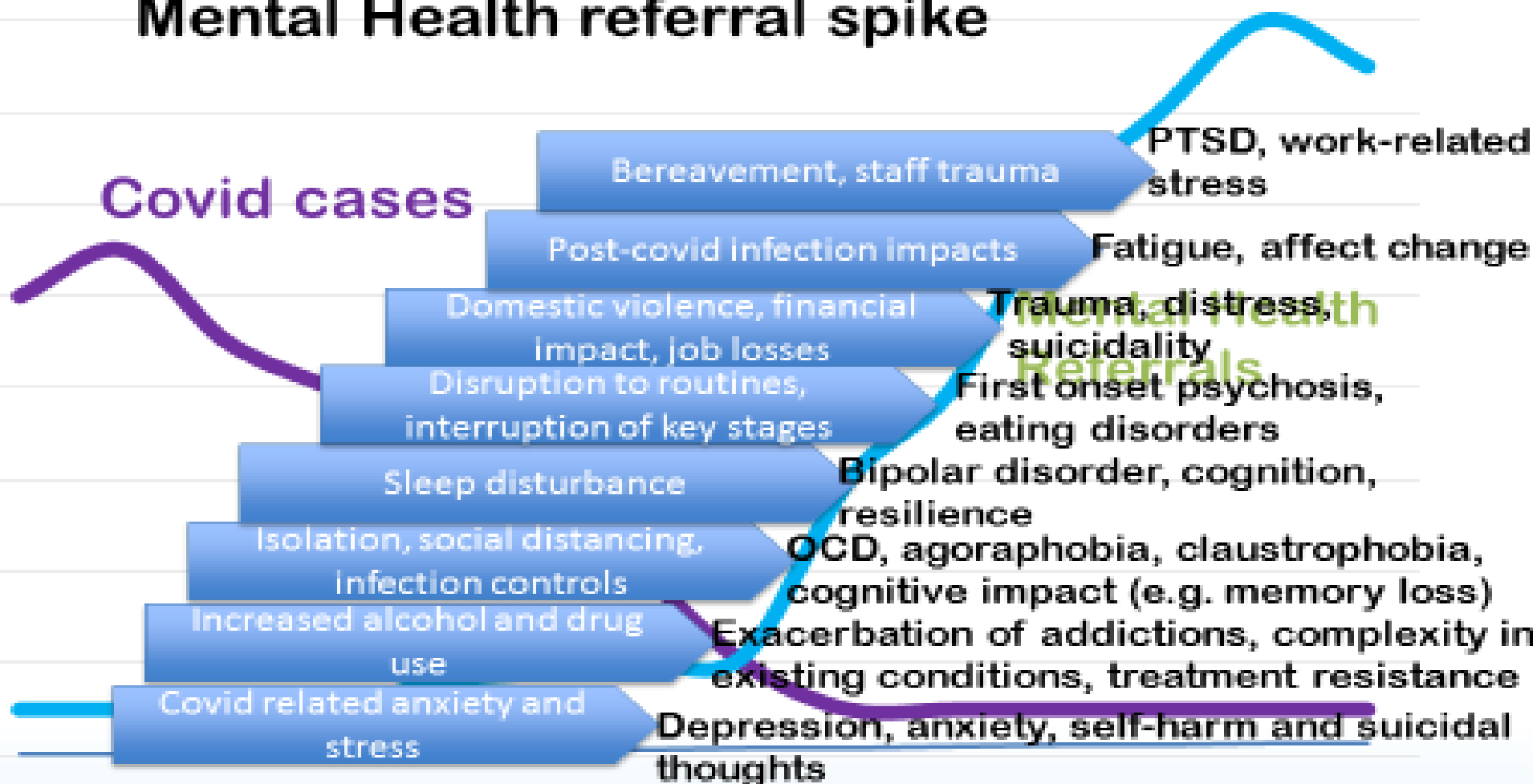
B. Short Period Following some limited relaxation of lock down but with strict social distancing continuing (1-2 months – May & June 2020)

Inpatient Configuration - As the spread of the corona virus in hospital recedes, the Adult and MHSOP Directorates will be required to decide how best to use to offer its current covid 19, wards capacity. Both Directorates will need to be mindful of the potential for a second peak in the virus and how to both accommodate this possibility alongside the reinstatement of 'new normal' services'.

Demand and Capacity Modelling to support local recovery planning

Version 4

We anticipate a possible post-Covid 19 Mental Health referral spike



The effective management of all health services require robust demand and capacity modelling to be regularly reviewed. Whilst in the crisis period of Covid 19 referrals to services have reduced (sometimes significantly); for some elements of the MH services, there was already a waiting list at the point of lockdown. In order to inform recovery planning to allow informed decisions on resource enhancement and redeployment, as well as risk and “expectations” management, it is important that this work begins urgently. Service leads should be asked to indicate whether they have the capacity and skills to undertake this work for all elements of their services or whether extra support is required so that this can be provided.

As a starting point, LHBs should explore:

- ✚ What are the existing waiting lists? What does the demand and capacity modelling tell us about the length of time to get back to “target” times from existing waiting lists?
- ✚ What does the fall off of referrals tell us about pent-up “normal” demand? I.e. if the usual referral rate over the “lock-down” period translated into a surge, what would that look like and how would services cope? How do we **‘FLATTEN THE ANTICIPATED MENTAL HEALTH CURVE’**
- ✚ Does any of the research/evidence base from a range of sources tell you about the degree and type of the Covid 19 pent-up and new demand? This should include any evidence from countries ahead in the Pandemic cycle.

Planning for additional/new demand – what information can help us?

Whilst we may be able to assess and plan for ‘pent up’ or delayed “normal” levels of demand and make some assessment of the needs of those with existing mental health conditions that have been exacerbated by the crisis, it will be necessary to take views and evidence from a range of sources on the nature and needs of additional demand for wellbeing and mental health support.

Information Sources:

It may be possible to stratify the possible causes and sources of information given what we know e.g. about the make-up of the employment market i.e. in Wales the Public Sector is the largest employer, with SMEs second. As part of the 4-6 week forecasting of demand **Lightfoot** are meeting with the MHCB shortly to offer support in thinking through this and how information is collected and used for planning purposes:

Impact	Data Source
Economic – loss of employment,	Fed of small business DWP

bankruptcy, debt	ESNR information Debt advice
Bereavement	Pattern of deaths, CALL, CRUSE and other voluntary sector sources
Domestic Abuse	Police Data / Domestic Abuse Agencies / CALL Line /
SUIs	Local and National
Local Referral Demand and needs profile	PCLT / PMHSS / PCCS / CMHTs / CRHTT /16 activity / 3 rd Sector/stepiau website and other MH website hits

Meeting the Demand - What services should we consider planning now to enhance to mitigate the effects of Covid 19 over the recovery phases?

From early surveys and existing knowledge we can plan on the basis of a reasonable assumption that we will need to expand certain elements of MH services. In the main, this is likely to be around the lower tier services model to allow the minimum and earliest intervention possible. This response should include a wide population based approach as well some more targeted and specialist services, with a particular focus on primary care. As a starting point, the following services should be considered for early expansion:

TIER 0

Flattening the MH curve:



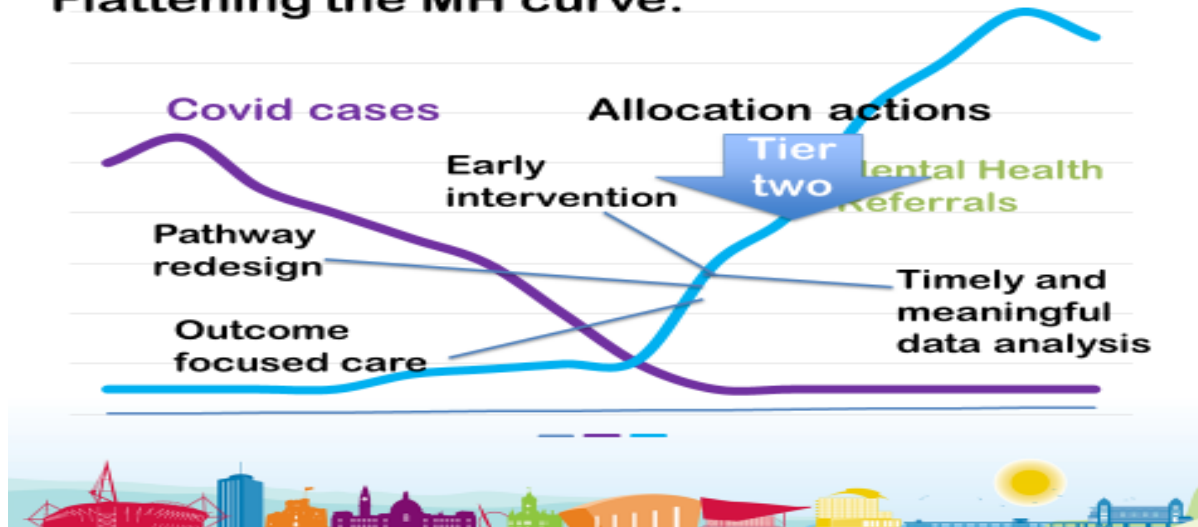
ACTIONS AT TIER 1

Flattening the MH curve:



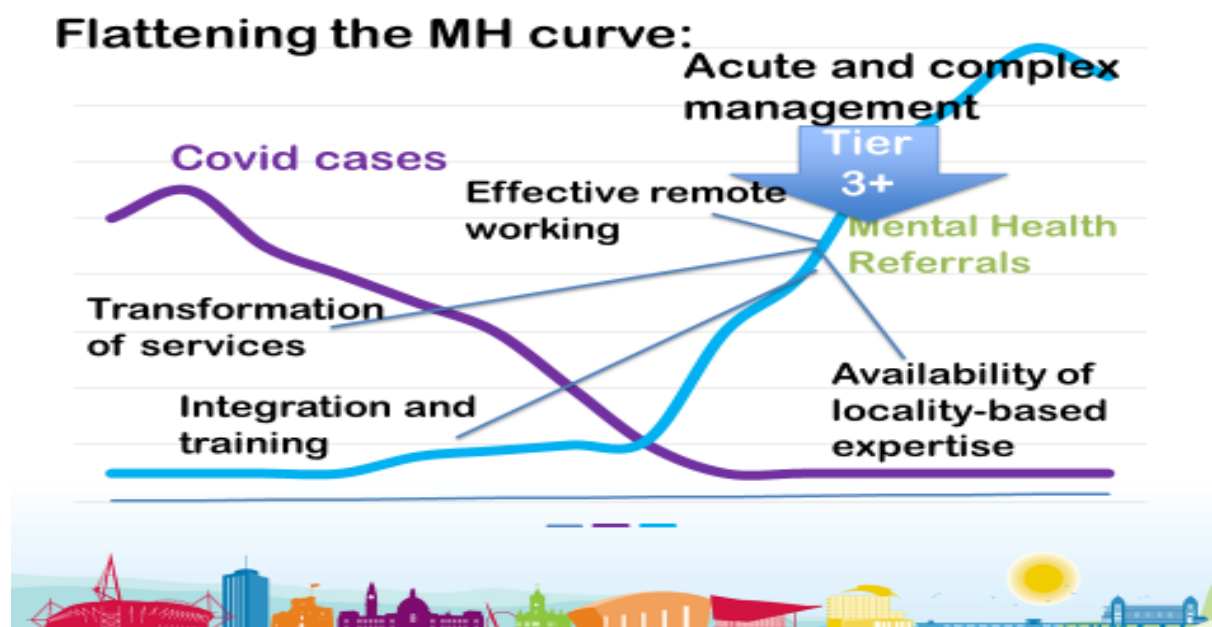
ACTIONS AT TIER 2

Flattening the MH curve:



ACTIONS AT TIER 3

Version



Demand Management preparation at Tier 0 and Tier 1

<p>Demand Management - Community resilience and voluntary organisations</p>	<p>Reduced waiting time for assessment and support</p> <p>Avoid medicalising healthy well-being responses to a health crisis by enabling projects to support community resilience</p> <p>People in Cardiff and</p>	<p>With the Support of Lightfoot, establish a monitoring method for real time referral activity into mental health to ensure demand is being tracked – to support decision making on resource allocation to meet the demand – May/June 2020</p> <p>Primary Care Liaison team to establish a Mental Health website address to seek support - Completed</p> <p>P&PTs to work nationally with Jim White to establish a UK stress control pack – Completed</p> <p>To maintain all elements of the current services – albeit pared back and delivered by different methods – complete</p> <p>For the CB to work with the National Program Director for Mental health in the WG to access a review of evidence related to post disaster mental illness presentation to inform demand management –</p>	<p>The impact of the CV19 on the mental wellbeing will be seen as a Mental Illness Issue rather than community resilience. To enable support to get</p>	<p>All</p> <p>P&PT DM 3rd Sector Organisations All</p> <p>Dir Of Ops & MH Research Lead</p>
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	Vale have early as possible access to mental health support if needed to flatten a potential 'mental health curve' and prevent storing up more complex problems	<p>Completed and circulated to all partners</p> <p>CB to participate in National Research to monitor MH impact over 3-5 years – Ongoing IW Principal Lead</p> <p>Review options for expanding capacity to meet need and present to Clinical Board – To include expansion of 3rd sector contracts, shifting resources and a specific Covid related service – May/June 2020</p> <p>To investigate the feasibility of a specific mental health covid helpline to divert all covid related mental health demand towards and ease pressure on generic services – the support model potentially on offer is being piloted in Pentwyn currently and offers a tiered range of interventions</p>	to those communities.	<p>Dir of Ops – Principal Investigator</p> <p>Dir of Ops Commissioning Lead</p> <p>DM s Dir of Ops</p>
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<i>Service User / Carer Comments</i>	<i>Recommendation</i>
<i>Demand Information</i>	<p><i>'interrogate the evidence base for the nature and degree of pent up demand – look at evidence from other countries ahead in the pandemic and local demographics'</i></p> <p><i>'Evidence that hitting people hardest in poverty (coronavirus: Mental Health in the pandemic, 2020) '</i></p> <p><i>'Wales faces the relative poverty rate in the UK – look to poverty experts such as the Bevan Foundation, Oxfam Cymry, WG Cross Party Group on Poverty etc.'</i></p>
<i>Inpatients</i>	<i>Were any/enough specialist beds made available for patients experiencing poor MH episodes or with existing conditions combined with Covid 19 infection, in secure conditions? With appropriately trained staff. Was this viable during peak infection? Were service users made aware of this availability? Were staff and service users adequately protected and secure?</i>
<i>Outpatients</i>	<p><i>Has the change in systems eg management of appointments engendered a sense of calm and orderliness in services or, once staff adjusted, had a different impact, both on staff and service users e.g. confusing and unsettling?</i></p> <p><i>Anecdotal feedback from non-emergency service users has been that most appointments have been organised more efficiently, therapy has been more effective and reassuring.</i></p>
<i>Planning for Demand</i>	<p><i>How helpful are behaviours of other nations in forming MH services, taking into consideration sociocultural factors and timescales of development of the pandemic? Do we use the same data for realistic comparison across the world which makes this research valid?</i></p> <p><i>Is the range of national decisions too great or variable for any useful comparison? Is there immutable evidence that any action has a positive</i></p>

	<p><i>effect of suppressing contagion whilst maintaining accessible supportive mental health provision?</i></p> <p><i>As we are still gathering data and will do so for years, current recommendations need to be elastic to adjust to responses to Covid 19 as hard (and soft) information becomes available. Current planning is speculative. We have to embrace informed uncertainty but remain flexible and reactive as the virus may remain a threat for many years. How do you define the “recovery phase” in mental health terms? Probably beyond the scope of this plan. <u>This qualification should be made clear at the beginning of the document</u></i></p> <p><i>Service users might want reassurance that if staff are working from home (while consulting with them), can confidentiality of their information be guaranteed still? E.G. could conversations be overheard by other members of the staff’s household; data storage security etc?’</i></p>
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Version 1.1

C&D. Some further relaxation of lock down but social distancing continuing (3-6 months – July – Dec 2020) & Ending of lock down and some social distancing measures relaxed (6-9 months – Jan 21 Onwards)



Post Covid recovery plan. What are the opportunities, developments and challenges ahead? Needs to be in Partnership via the TFMH Forum and SU/Carer led

Innovation	Patient Benefits	Actions and Timescales	Risks & Mitigation	Directorates Involved / Lead
1. Single locality points of access for PCCS & PMHSS via PMHSS.	<p>Improved GP access to PCCS</p> <p>Reduced waiting lists in PCCS</p> <p>Simplify Access for Service Users</p> <p>Reducing clinical waits and increasing access to self-help, therapeutic groups and one to one CBT via PMHSS for PCCS referrals is likely to benefit service users accessing a range of primary care-based therapies.</p> <p>Meets Locality /Cluster UHB Strategic Direction</p>	<p>During covid to centralize all referrals into PMHSS and PCCS with PMHSS to screened and triaged at a single point of locality access - completed</p> <p>Evaluate this SPOE with support of the WG 'rapid review' process in partnership with practical Solutions company – June & July 2020</p> <p>Closely monitor referrals into these two services from pre-covid (combined 1600 pm) – whilst monitoring impact of the new PCL team on referrals into these two services. To provide capacity where required based on the hypothesis that the post covid referrals will reduce - Ongoing</p>	<p>Potential to breach the Tier 1 PMHSS Targets when referrals begin to increase – this is currently unknown with an additional possibility of a surge in MH referrals</p>	<p>Psychology and PTs & PCIC HUB</p>
2. Agile/ Home working tech opportunities for staff to reduce dependency on office accommodation:	<p>More options for Staff, Service users and carers in receiving therapeutic care and assessment.</p> <p>Dellcovid laptops have been very popular.. Flexibility to access Wi-Fi around different health sites has benefitted specialist services who have less need to return to base making their work more effective and has enabled better social distancing.</p> <p>The limited availability of netbooks has also been popular with staff. There have been some complaints about the network stability and absence of video conferencing options.</p>	<p>Exploration of netbook purchases for specialist services and similar pooled resource for community teams to enable better social distancing, more efficient agile working and home working options. Ongoing</p>	<p>Homeworking experience has been excellent. Only drawbacks mentioned were that there is no skype function on the computers</p>	<p>All via Dan Crossland Head of I&T</p>
3. Video conferencing, digital clinical working. / video assessments and written online / silver cloud & Attend	<p>Positive feedback (Zoom based Perinatal baby massage group for example) for video,. Improving the ability of teams to engage in teleconference means a different approach to how technology is purchased in the future.</p> <p>Positive feedback from staff groups about the use of skype in meetings to improve communication and as a future development, attending ward rounds / MDTs virtually has been positively encouraged by generic and specialist teams to reduce unnecessary travel time and to improve regular</p>	<p>A largescale purchase of equipment for all areas of camera and headsets, monitors with integrated cameras, microphones and speakers are preferable to support roll out without exchanging desktops for laptops. Will await advice from digital lead on return from leave and develop a plan for how this can be evaluated across clinical boards. – Ongoing during May and June 2020</p> <p>WG requested to undertake a 'rapid review' of the impact of digital technology for clinical work –</p>	<p>there have been reported difficulties in some areas (Psychology and Counselling) where they are awaiting early roll out of Attend Anywhere</p> <p>The hardware to support the roll out is limited, 15 dual screens</p>	<p>All Directorates Dan Crossland Head of T&I</p>

anywhere	attendance.	Accepted and to undertake June/July 2020	have been provide along with a limited supply of cameras and headsets and iPads.	
4. Reviews of Community Services referral pathways / OPAs & chronic condition management / RAMP / RAG Rating of Caseloads	<p>Simplified access for GPS and Sus & Patients will be seen by the right person</p> <p>Reduced duplication and delay in care & Improved care for chronic mental and physical health care</p> <p>Clearer communication & Swift pathways of care</p> <p>Drugs for Dementia model works effectively</p> <p>Use of technology – less travel</p> <p>Standardise Community referral and care and treatment pathways</p>	<p>Programmes of work initiated to locate locality based services where possible such as:</p> <p>7 day availability, location of Emergency referrals, a review of Outpatient efficacy and value in the context of RAMP - aim to Reduce low value OPAs attended where safe and appropriate and provide choice and alternatives with the availability to the flexible MDT – including Physical HC</p> <p>Regular Review of caseloads using a recognised tool such as RCP</p> <p>IT systems – PARIS report – solution for MHSOP</p>	RAMP poorly understood and to include training and awareness raising to all staff	<p>Adult and MHSOP Directorates</p> <p>SU and carers</p> <p>CHC</p> <p>MHCB</p>
5. In Patients flow – identified as having uni-professional approach with delayed decision making and over dependency on hospital provision	<p>Inpatient flow in adult services requiring MDT approach and regular decision making forum - with resource allocated to flow – in partnership with the CCCTeam</p> <p>Timely and Improved inpatient stay – reduced delays</p> <p>Support in a crisis</p> <p>Safe discharge process</p>	<p>Introduce regular MDT decision making opportunities into in patient flow - Re-introduce Board Rounds where appropriate – use of Grand Ward rounds : review format, length and timetable for ward rounds – May /June 20</p> <p>Increase SALT provision for Dementia wards – Business case June 20</p> <p>Clarify role and function of REACT team in MHSOP – by July 20</p>		<p>Directorate Leads</p> <p>MHCB</p>
6. Review Day Services availability based on service user & carer need	<p>Improve communication</p> <p>Faster decision making</p> <p>Increased available clinical time, less travel for staff & SUs</p> <p>Avoid crisis in Community</p> <p>Focussed treatments in day care</p>	<p>Establish working groups to consider where appropriate:</p> <ul style="list-style-type: none"> • 7dpw working • To support MHSOP patients as part of crisis service • CHL support in ARU 		<p>Directorate Leads</p>

	Availability based on service user and carers needs not the services historical provision	<ul style="list-style-type: none"> Improved flow to Grand Avenue Respite facility Alternative to daily REACT visits for period of time Review Transport (Carer drivers?) Role and function of CRU 		
7. Physical Healthcare – more blended approach particularly between MHSOP and Medicine CB	<p>Patients can remain on MHSOP wards and not transferred out to MEAU / Medicine wards for all Physical needs.</p> <p>Patients cared for in familiar environment Co-morbidities cared for together</p> <p>Upskilling staff – helps with staff wellbeing, job satisfaction and retention</p> <p>Closer working with Medicine service</p>	<p>Physical Health Senior Nurse post filled - complete</p> <p>Training programme with LED / Medicine – June /July</p> <p>Programme for competencies (staff passport?)</p> <p>OOH Support</p> <p>Data collection around physical health changing needs</p> <p>R&D opportunity</p>	Common vision for integred model with MCB	DM – MHSOP DM-Adult
8. Complex Care Commissioning Team - Direction of travel & partnerships and decision making tools	<p>170/80 service users in CHC OOA placements require appropriate specialist care from an MDT in a timely manner. In addition anyone with complex needs in local hospital provision requires seamless discharge. Currently this provision is patchy.</p> <p>Decision making currently is not based on</p>	<p>For the MHCBC to establish development arrangements to address these long standing issues with an aim to:</p> <ul style="list-style-type: none"> Decide the MDT model of care – case management provision Recruitment and retention to the team Standards for service delivery Partnership agreement over placement decision making tools 	Partnership agreement inhibited due to cost implications – escalate to board partnership forum	CCCT DON DOO
9. Improve staff awareness of suicide risk in light of COVID, and provide tools to support people with mitigating this risk.	<p>People may be at higher risk of suicidal thoughts, plans and actions in light of biopsychosocial impact of COVID-19. People may benefit if professionals had increased knowledge/skills as below:</p> <p>Suicide awareness for all UHB staff (recognise signs of suicide risk in our families, our colleagues, our patients and our communities.</p> <p>Suicide response for all UHB staff who assess patients (eg GPs, EU staff)</p> <p>Suicide response for MH staff who complete risk management plans with patients (will improve outcomes for patients taken on by the Mental Health Clinical Board – it will give staff the tools and confidence to assist patients and their families in understanding their risk, via open conversations and the co-</p>	<p>For the Consultant Nurse to submit SBAR with options and associated costs – complete</p> <p>For the MHCBC to consider supporting the SBAR submitted by the Consultant Nurse - ??</p>	<p>Total initial cost = £8880.00 inc VAT.</p> <p>Total ongoing costs = £800 pa relicensing cost per trainer PLUS booklet costs approx £1 per booklet per attendee.</p> <p>Independent trainer license (to train outside partner colleagues) = £350 pa per trainer.</p>	<p>Cons Nurse All Directorates</p> <p>Other relevant agencies if MHCBC supports full breadth of the proposal.</p>












	<p>production of a personal Safety Tool).</p> <p>Suicide awareness for associated partners eg police (at a small extra cost – this would mean that appropriate support is offered as early in the crisis as possible, thereby reducing risk).</p>		<p>This training can be delivered online which is key in light of social distancing, but the UHB will need to ensure all staff have access to the appropriate online platform.</p>
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Rapid Review Methodology (referred to in the Action Plan)

A specification, methodology and vehicle for these reviews is under urgent consideration but should include perspectives from both staff and service users/stakeholders as well as any available performance, outcome and financial data. Voluntary sector input will be important to this work and arrangements are underway to provide some early feedback on experiences. The WG have agreed to participate with C&V MH services to review the Primary Care SPOE and The experiences of people giving and receiving digital MH care and treatment.

We will also need to consider whether and to what extent CHCs should be engaged or informed (recognising that they have not played a part in the Covid 19 emergency changes for mental health services

Other Current Initiatives /Innovations

-  Recovery College
-  Open Dialogue
-  SU Engagement Post /Coproducton
-  BAME Accreditation
-  Crisis Care Concordat
-  Care Aims
-  Prison Transformation
-  Patient transport
-  Trauma Missing Middle
-  PICU Expansion
-  Dual Diagnosis Action Plan

 Trial of Bodycams to reduce patient and staff injury

<i>Service user and Carer Comments</i>	<i>Recommendations</i>
<p><i>Geographical spread; for urban and rural areas, reflecting impact on social distancing and access to services in the light of changes to business/transport etc.</i></p> <p><i>Transition from existing services to “new normal” services; establish overlap/recap period ensuring continuity.</i></p> <p><i>Consider endings, beginnings and continuity of services with provision to pickup again if necessary rather than have to start new therapy all over again.</i></p> <p><i>Service delivery first points of contact - how do GPs accommodate increased demand for MH services without additional training and resources ? Would the larger model of combined healthcare centres with a more developed, dedicated MH facility for initial assessments and outpatient therapeutic support, combined with wellness facilities at e.g. leisure centres improve service delivery?</i></p>	<p><i>SU C encourage service users and carers to attend routine appointments again and be reassured it is safe to do so – reassure about handwashing and social distancing’</i></p> <p><i>‘Agree not to pathologize normal stress responses’</i></p> <p><i>‘Increase the potential of lower tier innovations’</i></p> <p><i>Cavamh on line forum is a good place to chat – low level peer resilience coaching model’</i></p> <p><i>‘Organisations like Headspace and Calm offer people low priced Apps to help manage situational distress’</i></p> <p><i>Considering new channels of communications with flood of new service users who are unfamiliar with availability and means of accessing services online or phone, remotely, but not neglecting face to face engagement which may be more resource-heavy.</i></p> <p><i>Consider changes, substance misuse, accessibility to substances and opportunities to use, has there been any baked shift? This may be an area for research.</i></p> <p><i>PTSD impact statement and forecasting; assessing impact of isolation</i></p> <p><i>Perinatal care</i> <i>explore potential increase in fear of accessing healthcare because of potential infection; adding anxiety on top of anxiety - lock into service contacts on wards/teams encouraging them to consider and communicate need for regular physical health checks in safe environments for vulnerable patients. Monitor situation, with feedback loop to MH services via wards.</i></p> <p><i>Can we use this situation to instigate further training and better communication between services as a longer term objective?</i></p> <p><i>The above applies to all MH service users manifesting physical symptoms too, eg self harm, substance misuse etc. where service users may choose not to seek treatment from A&E because of fear of viral infection. By addressing these issues now we can alleviate the potential of more serious harm as physical and mental health worsens longer term. Also impacts on planning.</i></p>
<p><i>In addition to Welsh Govt/C&V endorsed MH and Wellbeing activity there are abundant apps and online resources on broadcast, written and social media. In a</i></p>	<p><i>Immediate and short term action: encourage the Welsh Assembly Government to publicise a message “It is understandable if you are not coping at the moment, many people are finding things difficult...” or similar ... with information about how to contact people for mental health support via a centralised telephone number and online (Training and capacity, safety and security issues) Staff/volunteers, MH trained to manage calls and know where to signpost. It is crucial that volume of calls can be met</i></p>

<p><i>heightened or low state, in isolation, it can be difficult to pick through what is relevant and what is potentially harmful, which are free or have hidden costs. There is an increased burden on the individual is to be well and coping, or expressing negative responses to Covid 19, with attitudes more polarised than usual. These extremes are fed by online activity and peer pressure to conform. What support is available to enable a person to pick their way through excessive “wellbeing” pressure? Is this an information/communication issue to be addressed in a wider context - mental health week, information announcements, via policy making?</i></p>	<p><i>supportively if this service is to be effective.</i></p> <p><i>Straying into micro managing here but persuade Welsh Govt to set up the call system... this is an opportunity to engage people who have been furloughed by providing a positive skills development opportunity and activity during this difficult time. Also potential capacity building for MH staff training or in education or peer support, to develop experience and improved service delivery in the long term; rolling a problem and meeting WAG commitment to MH service delivery to improve the overall wellbeing of the people of Wales in the longer term (even with the current challenges we are facing in this pandemic).</i></p> <p><i><u>Research outcome:</u> this service may also contribute baseline information about state of mental wellbeing within the Vale and wider</i></p> <p><i><u>Costs:</u> Consider approaching organisations/business wanting to publicise Corporate Social Responsibility covering their marketing at this time e.g. through Public Health Wales.</i></p> <p><i>Happy to discuss this further if you are interested but do not want to derail basic service delivery and planning.</i></p>
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5. RESOURCING & ENABLING FRAMEWORKS - CAPITAL INFRASTRUCTURE

The following capital schemes are key enablers to support our clinical board priorities are in progress:

Major Capital or Discretionary Capital Requirements – To Be Completed

6. ENGAGEMENT - Key schemes for discussion with CHC/ Public in 2020

The MHCB with Cavamh has now established a fortnightly digital meeting ongoing until further notice to maintain continuous engagement with service user and care groups. Through May and June 2020 the MHCB has been developing a health focussed plan from its directorates and clinical board as the basis of a discussion with partners to enable a whole system recovery plan from Covid 19 to develop. This has recently been shared with the Community Health Council (June 2020) to consider the service changes that will need support, consultation and engagement. Comments from the CHC, SUs and Carers are being fed

directly back into this plan prior to recirculation. The Community Health Council feedback on the plan has been initially positive with a request to summarize the headlines of the changes for them and identify where support and or engagement is required.

7. Glossary of Terms

<i>Acronym</i>	<i>Description</i>
1. ARU	<i>Assessment and Recovery Unit – acute day services for older people based in UHL</i>
2. BAME	<i>Black and Minority Ethnic</i>
3. BPD	<i>Borderline Personality Disorder</i>
4. CA	<i>Care Aims</i>
5. CALL	<i>National Mental Health Call Centre</i>
6. CB	<i>Clinical Board</i>
7. CBD	<i>Clinical Board Director</i>
8. CCCT	<i>Complex Care Commissioning Team</i>
9. CD	<i>Clinical Director</i>
10. CHC	<i>Community Health Council – watchdog organisation for health services</i>
11. CHC	<i>Continuing Health Care</i>
12. CHL	<i>Care Homes Liaison – Linked to MHSOP Services</i>
13. CMHTs	<i>Community Mental Health Teams</i>
14. CRHTTs	<i>Crisis Resolution and Home Treatment Teams</i>
15. DETOX	<i>Detoxification – PINE Ward in Hafan Y Coed</i>
16. DHH	<i>Dragons Heart Hospital</i>
17. DOO	<i>Director of Operations</i>
18. DON	<i>Director of Nursing</i>
19. DWP	<i>Department of Work and Pensions</i>
20. EAC	<i>Emergency Assessment Clinic – based at Hafan Y Coed</i>
21. EDSOTT	<i>Eating Disorders Specialist Team</i>
22. EHQIA	<i>Equality Health Impact assessment</i>
23. FEP	<i>First Episode Psychosis – Headroom based at Glaballink</i>
24. FORT	<i>Community rehabilitation team</i>
25. HYC	<i>Hafan Y Coed</i>
26. IAS	<i>Integrated Autism Services</i>
27. IT	<i>Information Technology</i>
28. LA	<i>Local Authority</i>
29. LED	<i>Learning and Education Dept</i>
30. MDT	<i>Multi-Disciplinary Team</i>

31. MEAU	<i>Medical Emergency Assessment Unit</i>
32. MHCB	<i>Mental Health Clinical Board</i>
33. MHSOC	<i>Mental Health Silver On Call</i>
34. OCD	<i>Obsessive Compulsive Disorder</i>
35. OD	<i>Open Dialogue</i>
36. OOHs	<i>Out of Hours</i>
37. OPAs	<i>Out Patient appointments</i>
38. PCCS	<i>Primary Care Counselling Service</i>
39. PCIC	<i>Primary and Intermediate Care Clinical Board</i>
40. PCLT	<i>Primary Care Liaison Team – Works out of GP practices</i>
41. PICU	<i>Psychiatric Intensive Care – based at HYC</i>
42. PMHSS	<i>Primary Mental Health Support Service – Associated with Tier 1 targets in MH</i>
43. PPE	<i>Personal Protection Equipment</i>
44. PTs	<i>Psychological Therapies</i>
45. PTSD	<i>Post Traumatic Stress Disorder</i>
46. RAG	<i>Red Amber Green – rating scale often used to assess complexity or progress against action plans</i>
47. RAMP	<i>Rapid Assessment Process – initiated to support an improved service for people with ongoing needs in cmhts</i>
48. RCP	<i>Royal College of Psychiatrists</i>
49. REACT	<i>MHSOP Equivalent of the Adult Crisis Teams</i>
50. RTT	<i>Referral To Treatment – associated with performance measures popular with NHS services</i>
51. SALT	<i>Swallow Team</i>
52. SHED	<i>Specialist Eating Disorders Team</i>
53. SPOE	<i>Single Point of Access</i>
54. SUIs	<i>Serious and Untoward Incidents</i>
55. TFMH	<i>Together for Mental Health – Welsh Strategic Plan for Mental Health</i>
56. UHL	<i>Llandough Hospital</i>
57. UHW	<i>Health Hospital</i>
58. WG	<i>Welsh Government</i>
59. WHSCC	<i>Welsh Health Specialist Commissioning Team</i>
60. YOD	<i>Young onset Dementia – team based in Barry Hospital</i>