Report of the Department of Health and Social Care C19 Task Force

Mental Health and Wellbeing Advisory Group

Summary and Priority Advice

1. All service users known to mental health services must have the opportunity to review, with their care manager, their care plan, to ensure that these plans include provision for ongoing support. This also means clear care co-ordination arrangements and a central point of contact for communication of service availability (e.g. in the light of potential lockdowns), including crisis support and consideration of carer needs.

2. All statutory services must be required to ensure they remain in regular contact with service users, that risk is managed with them and any commissioned providers throughout the pandemic and beyond. Significant evidence indicates that service discontinuity (i.e. no contact from care co-ordinators, withdrawal of section 117 aftercare) remains the experience for many people, including those with severe mental illness.

3. The continued availability of and investment in crisis support must be a central feature of an effective range of accessible local mental health and wellbeing services.

4. The principles of personalised care and an explicit recognition of inequality as a barrier to access and better mental health outcomes must guide digital and virtual service offers and commissioning assumptions of these. The risks of digital exclusion are particularly pronounced for people with severe mental illness, people from BAME communities and those with lower socio-economic status.

5. Access to culturally appropriate advocacy services must be maintained and enhanced, with clearly communicated protocols for the continuity of services, that are both readily available and regularly reviewed.

6. A clear and targeted focus on prevention (e.g. welfare rights, information, debt and money advice, housing support) that recognises and responds to the structural and intersectional determinants of mental illness and inequalities in mental health outcomes, particularly for BAME people and communities, is required of all services.

7. Local health and social care systems must renew (i.e. through Health and Wellbeing Boards) commitments to parity of esteem, to maintain access for those people who are currently known to services *and* those who are

experiencing mental health distress for the first time. This will include the need to ensure access to appropriate personalised care and support for all service users, particularly for BAME people and communities.

8. Stability and continuity of commissioned services and their ability to keep people safe in the immediate future, will benefit from meaningful co-production between service users, commissioners and providers. Commissioners must recognise the intelligence that VCSE providers possess on individual and local needs and circumstances and facilitate sufficient flexibility, particularly in relation to contract management, associated KPI's and delivery and allow providers to adapt and blend services accordingly.

9. Adult Social Care authorities and relevant services commissioned by them must be proactive in identifying friends and family carers of people with mental health challenges and respond accordingly. This means providing clear in messaging and information that confirms a) carers are entitled to statutory support and b) where they can go to request that support.

10. Stable services that provide continuity of care and support that keep people with mental health challenges safe rely on a confident, capable social care workforce, across statutory and VCSE sectors. Investing in and supporting the confidence and capability of this workforce is an essential requirement for national guidance, regulatory bodies, inspection and infection control arrangements and local commissioning systems.

11. The restoration of mental health related adult social care budgets to 2010/11 levels is a priority; in 2018 this was estimated at an additional £1.1 billion per annum. A resolution to this continued gap between demand and resources must also recognise the need for targeted investment in those areas and communities with greatest needs and most disproportionately affected by C19.

12. The essential role of Adult Social Care (as expressed in the powers and duties of local authorities in the Care Act) in the meeting the needs of people with mental health challenges and their carers and in promoting population mental health and wellbeing, must be explicitly recognised by the NHS and its leadership at national and local levels. This also means that all councils with responsibilities for social care and their VCSE provider partners must be able to engage with and secure strong input to the NHS C19 cells and NHS mental health related planning and delivery arrangements at local levels.

Full Report of the Advisory Group

1. The C19 pandemic has highlighted **the essential role of Adult Social Care (as expressed in the powers and duties of local authorities in the Care Act) in meeting the needs of people with mental health challenges, keeping them safe,** preventing future mental health issues and in the promotion and maintenance of the mental health, independent living and the wellbeing of local populations. Through their Adult Social Care functions, councils are also the primary local commissioners and funders of VCSE mental health and wellbeing services, the independent and not for profit sector.

2. As per its terms of reference (page 16), the Advisory Group has considered the context of and the **priority action required for stability and continuity in the social care sector, in order to respond to the mental health and wellbeing needs** of people and communities, to ensure that services can continue to navigate and deal with the effects of C19 and plan for winter 2020/21.

3. The Group is clear that the advice and guidance to help meet this objective should be designed to ensure that the following expectations are met:

- **people with mental health challenges are protected from the virus.**
- **all efforts are made to avoid creating distance between people and their family/community of choice.**
- **people with mental health challenges remain connected to essential services; and**
  personalised services are in place, with a workforce to deliver and that all efforts are made to protect that workforce from the virus.
- **there is a clear understanding of the essential role of social care and local authorities in the delivery and funding of mental health and wellbeing services**

4. The Group's first meeting considered the impact of C19 to date on the safety and wellbeing of **people with lived experience** of mental health challenges, particularly those people with severe mental illness and including people who receive (or have a right to) social care and support arranged by Local Authorities under the Care Act. The Advisory Group has been clear that **this perspective must be central to all advice and guidance**, in the context of the following considerations and evidence:

- the impacts of shielding on people with pre-existing mental health challenges and the psychological effects of C19 on the wider population.
- the effects of isolation and the requirement to self-navigate (with not everyone able to do this).
- the lack of clear, accessible information reported by service users, providers and commissioners.
- service dis-continuation e.g. reduced or nil access to integrated care coordination, or care and support planning in a timely way; minimal review of care plans and poor proactive management of care and crisis plans (where they exist) and increased risk of escalation to crisis.

- insufficient person-centred lens on: needs assessments; prioritisation of inequalities (i.e. BAME people and communities); people in contact with the criminal justice system; housing and accommodation.
- digital availability and inclusion; digital poverty and inability and reluctance to access on-line services and support, as a result of demographic and other considerations.
- reduced onward referral for crisis help e.g. given restrictions on AandE accessibility.
- a lack of access to social care and support or understanding of people's rights under the Care Act.

5. At the onset of the pandemic, **unprecedented and well documented increases in calls to anxiety helplines and support services were recorded**. This included significant numbers of people seeking help and support for the first time. In addition, some localities have experienced reduced access to and the availability of social care and support, as a result of both formal Care Act easements and the additional pressures on services. Some services report that they are now beginning to see an increase in other specific presentations from existing service users e.g. self-harm and domestic violence-some of which is evidently historical. Approved Mental Health Professionals are also reporting an increase in people in mental health crisis, including people e who have not previously been assessed under the Mental Health Act.

6. Providers anticipate the nature and extent of the demand for services to remain dynamic, as the psychological and mental health impacts of C-19 continue to be felt. This demand has too often resulted in poor resolutions, poor access to crisis support and an increase in unresolved calls. **As such, local systems should be advised of the need to resource specialist (anxiety, OCD, phobias) helpline support, ensure confidence in the accessibility and quality of crisis services and specifically the availability of helplines supporting BAME people and communities.**

7. Services have also reported that many of those service users who were most socially excluded pre C-19 have experienced a deterioration in their mental health as a result of loss of access to a wider network of support e.g. social workers, care co-ordinators, support workers education and community activities. Providers have also identified a **decline in the physical health and wellbeing of service users** as a result of lockdown restrictions and limited dietary options. Moving forward, **many providers are taking the opportunity to review and support people's wider health needs** (e.g. flu jabs) in the context of the fact that the physical health of many service users has been compromised by the restrictions of lockdown. However, to be sustainable this will require additional investment in services to help those people return to pre-C19 health and prevent further decline.

8. These challenges notwithstanding, the Advisory Group has heard that VCSE, Independent sector and not for profit organisations and providers (commissioned by local authorities' through their adult social care duties) have, for many existing mental health service users, been able to 'step in' to the space vacated by some statutory mental health services and work both flexibly and effectively to help provide some continuity of care and help to keep people safe-in addition to

maintaining existing services. **However, it's also evident that for many, accessing this support can be contingent on a level of personal knowledge about and contacts in local health and social care systems and the wider community**. As such the Advisory Group recommends the need for guidance and advice on:

- the imperative for a clearly identifiable, central point of contact, particularly for people with severe mental illness, accessible through both Local Authority social care and NHS services.
- regular and meaningful reviews for people with a care plan and implementation of crisis plans;
- meaningful access to care coordinators, emergency support and community social work teams, clarity on emergency access points (not AandE) communicated effectively to existing and prospective service users and VCSE providers;
- access to continuity of support for those in contact with the criminal justice system (e.g. those being released from prison following a period of detention under the MHA and under S.117 aftercare provision, those who may have been arrested or sentenced to mental health treatment requirements, or those leaving prison with mental health challenges and rights under the Care Act);
- local shielding policy and practise, with a clear, targeted focus on co-morbidities, inequalities and diversity, carers and managing mental health;
- the commissioning and delivery of a range of supported living for people with mental health challenges and the type of personalised support required, for example, for people with learning disabilities, autism and high levels of support need; and
- why genuine co-production is essential to the reconfiguration, commissioning and provision and review of services that help to keep people well and safe during C-19.

9. The Group's discussions have also confirmed the need to review and ensure continued **accessibility to advocacy services** (which are largely commissioned by Local Authority adult social care services) and the **imperative for these to be culturally appropriate**. The requirement for effective advocacy is particularly important in the light of reports that certain settings (e.g. locked wards) have not permitted access. Whilst remote or digital offers may offer an alternative means for providing this essential service, they are not viable nor possible (e.g. as a result of poor IT connectivity, etc) in all circumstances and settings. For those **people for whom face to face is the only option** e.g. lack capacity, struggle with communication, enhance risk assessment processes have been required to provide service and fulfil statutory duties. **There are opportunities to look at the continuity of care from prison release/criminal justice setting with the development of new through the gate services, such as NHS England's RECONNECT service**.

10. The i**dentification and the promotion of protocols for the continuity of culturally appropriate advocacy services**, is necessary here, along with examples of where barriers to access have been negotiated.

11. The Advisory Group has also been made aware of **ongoing concerns with the availability of crisis support**. Whilst some crises houses are still running, there

has been a loss of crises cafes and support, with the lockdown rules impacting on access to services. As we anticipate moving to the next phase of the pandemic and the prospect of further local lockdowns, the need for advice here is clear, particularly in relation to the reintroduction of services and other alternatives**. Both statutory and VCSE sector social care and social work support is an essential element of crisis mental health support, including the ability of AMHPs to access alternatives to hospital admission, in order to reduce both detentions under the Mental Health Act and unnecessary pressures on inpatient services**

12. The pandemic has both accelerated and **increased the provision of mental health and related services by both statutory and VCSE mental health and wellbeing providers through digital means** (including telephony). It's clear that the remote provision of services via digital has played an essential role in enabling continued access in the context of lockdown and social distancing requirements-particularly for those services users who may have been shielding as a result of clinical vulnerability. Indeed, Advisory Group members with lived experience have also detailed how online appointments that do not require physical attendance in psychiatric settings can also reduce anxiety and help maintain their sense of mental well-being. Some providers have also indicated that people who use their services have reported that they have benefitted from some online consultations with their GPs and other health care providers.

13. However, C19 has also highlighted that **significant barriers to digital access remain**, with a survey of 300 service users in Liverpool by one VCSE provider indicating that the nature of digital exclusion was greater than had been anticipated before lockdown. Age and poverty are key determining factors, as are the pressures on household budgets (e.g. food and heating on a weekly budget) which prevent access to equipment and digital provider networks-including for those who might prefer a digital offer.

14. Even in those circumstances where people have access and digital means, an additional issue can be the suitability of service user's home environment (e.g. those receiving help and support for their mental wellbeing as a result of experiences of domestic violence)
which may not offer appropriate, therapeutic or private setting for service-including for those for whom a preference might be digital. **Identifying and resourcing alternative C19 secure settings where people can access and receive digital service offers can present additional costs to providers, which need to be recognised. The ability for providers to access and provide services from NHS estates that are not currently in use would help here.**

15. There is also a need to acknowledge that there is a **growing cohort of individuals for whom the statutory duty to provide service can only be fulfilled by a face to face** offer and if this is not possible, then there is an increased risk that they will 'fall through the net' and needs will escalate-particularly if C19 restrictions continue. Whilst many CandYP (18-25) indicate they are happy with digital via apps etc a **significant number indicated that face to face is their preferred option**; one provider reports a current waiting list of 50 such young people for counselling support on this basis.

16. The Advisory Group is also aware that that the **provision of remote counselling and peer support to carers** of people with mental health needs may not meet acceptable quality thresholds, given the lack of privacy in carers' home environments.

17. Moreover, **digital means and offers do not necessarily equate to reduced operating costs and savings for commissioners.** The group is clear that commissioning and provider **decisions about the use of digital must, in the first instance be driven by the need to improve access, choice and secure the best outcomes for people with mental health challenges**.

18. The Advisory Group has in the first instance considered the impact of C19 on people currently known to mental health and related care and support services. However, it has also recognised the need to **address wider population (public) mental health needs that will** present to services as result of C19 and which are not currently funded**.** Services are beginning to report help now being sought by significant numbers of individuals who had not previously required MH support or services but whose mental health is now impacted by the effects of C19**. Planning and resources for this increase in demand for services is clearly an imperative as is the need to consider how other public policy interventions e.g. welfare rights, benefits and debt advice commissioned by local authorities, can help prevent a deterioration in mental health.**

19. Long standing **inequalities in access to and the availability of services, often conditioned by variations in local funding arrangements**, have been compounded by C19 and the challenges experienced by some local commissioners in interpreting and applying national guidance. **This includes the provision of s117 aftercare services and access to personalised social care and support under the Care Act.** In addition, the lack of effective commissioning and resourcing of local housing and community support services for people with mental health challenges, often jointly with the NHS, remains a major issue and has been exacerbated by C19. **These inequalities both access and provision reflect and reinforce the structural inequalities in society that drive the need for mental health services and the racial discrimination persists in the health and care system and wider public service infrastructure**.

20. **A social justice, rights based (social care) approach to mental health services, both in terms of access and prevention, provides a principles framework for addressing inequalities across the health, care and wider system moving forward**. The recently published ADASS statement on the steps required to guide wider social care reform endorses this approach. It calls for "**consistent local processes to address inequalities using the tools including anti-discriminatory practice, population level strategies and targets, community development and anti-poverty strategies, and economic development targeted at promoting equality"** and for "**a mechanism to describe annual progress is put in place**"[1]. The Mental Health Patient and Carer Race Equality Framework, currently being developed by NHSEandI, may also help to

[1] https://www.adass.org.uk/media/8036/adult-social-care-shaping-a-better-future-nine-statements-220720.pdf

ensure a clear and rigorous focus on addressing these issues across the health and social care system.

21. Many people supported by service providers have reported that they have coped well; so far. However, we need to **avoid the assumption that they will continue to do so given what is not yet known about medium/long term effects of lockdown on mental health**, the indeterminate nature of the presence of the virus in communities and how this will continue to impact on lives and the way services and support can be provided. Indeed, both providers and commissioners are now witnessing increases in presentations of C-19 related psychosis and PTSD, for example.

22. People with lived experience have also shared with the Advisory Group the fact that, as lockdown has eased, being able to make informed choices about what to do next is particularly problematic, **not least in the continued absence of contact from CMHTs and care co-ordinators and the lack of support for developing an individual plan to manage re-introduction into society.** The Advisory Group is also aware that in many areas social care support for mental health is provided separately from NHS CMHTs, or is co-located, yet outside the care coordination process. **This inevitably makes it more difficult for service users to access integrated health and social care. A resolution that is consistent with the expectations of NHS England's Community Mental Health Framework for Adults and Older Adults and peoples' right to services under the Care Act, is required to address this.**

23. **Key to the stability of services in the immediate future is meaningful, ongoing dialogue between service users, commissioners and providers**. C19 has in many areas demonstrated how more equal relationships that recognise that, in addition to identifying and responding to needs, providers possess the knowledge and skills that are essential to keeping people and services safe in the current public health crisis (and indeed and wider ambitions for service modernisation and improvement e.g. NHS Community Mental Health Framework for Adults and Older Adults. **It is essential that local government and the wider social care sector is supported and adequately resourced appropriately if the ambitions of this Framework are to be realised.**

24. With the expectation that the operating environment for services is likely to remain both dynamic and unpredictable, it is essential, **that commissioning recognises the 'live' intelligence that providers possess on individual and local needs and circumstances and that they facilitate sufficient flexibility, particularly in relation to contract management and delivery,** accordingly.

25. The fast tracking of **digital and remote service offers by many providers has demonstrated the sector's readiness and adaptability to respond to the mental health service imperatives of the crisis** and of course the potential long-term utility and value of those offers for many service users. However, as discussed above, demographics and social and economic factors (e.g. poverty) present **barriers to universal accessibility**.

26. In addition, C19 has confirmed that for many service users, face to face services are the preferred, if not the only, viable option. There are also a range of emerging **effective practise issues (including safeguarding)** that must be

considered when designing services and making care management arrangements based on digital access. **The principles of personalised care and recognition of inequality as a barrier to access and better mental health outcomes must guide digital service offers and commissioning assumptions of these**.

27. Providers have evidently found a range of alternative ways to respond to the operating challenges posed by C19, in order to maintain providing services and support with and for people. It's clear that the most successful of these have been where **genuine co-production between service users and providers** has been a central element of those re-configured services and where commissioners have recognised and supported this.

28**. Co-production must, therefore, be the central guide to commissioning and provision moving forward, not least given how C19 has illustrated how effective it has been/is to personalised care that keeps people safe**. This will mean commissioners ensuring that:

- **they share with providers their planning assumptions for the next phase of C-19 and beyond.**
- **they continue to enable the provision of flexible, blended service delivery models and avoid assumptions that returning service offers to pre-C19 state is always feasible or necessarily in the interests of all service users.**
- **they recognise that providers are well placed to understand and indeed possess good qualitative and quantitative data on the additional and increasing mental health needs that C-19 is driving, for example in relation to safeguarding.**
- **contract management recognises the costs associated with the need for ongoing service flexibility and re-configuration and diversification to meet needs.**
- **they recognise the demands on provider organisations resources and capacities during the pandemic and apply pragmatism when considering the timing of tendering / procurement of contracts accordingly.**
- **they adjust contract expectations and specifications with an emphasis on achievable outcomes as distinct from outputs and recognise the ways in which the adaptation and modification of services by providers** (and blended service offers) has been and is likely to continue to be effective in achieving these, within the context of the likelihood of a 2nd wave of C19 and any subsequent lockdown requirements.[2]

29. **The distribution of C19 central/local funding has not been sufficiently targeted on areas/communities with greatest needs**. This has been particularly evident for those providers working in localities where there has been an escalation and accumulation of mental health needs across populations and concentration in communities with pre-existing and multiple disadvantages. **These resource**

[2] https://www.centreformentalhealth.org.uk/sites/default/files/2020-04/Supporting%20mental%20health%20in%20communities%20during%20coronavirus%20crisis_.pdf

challenges take place within the context of the estimated additional £1.1 billion per annum required over existing social care spending, to restore mental health related adult social care budgets to 2010/11 levels by 2030[3]. **Addressing this deficit and working with providers to ensure greater equity in the accessibility and provision of services also requires recognition of the critical role played by local authorities, through their responsibilities for adult social care, in supporting and resourcing a capable VCSE mental health and wellbeing provider sector.**

30. The Advisory Group has also considered and received evidence on the impact of C19 **on the provision of social care services and support for people with needs arising from alcohol and substance misuse**. Services have reported that:

- with many community pharmacies have closed during lockdown, the ability to provide supervised consumption of opiate substitutes has been compromised.
- registrations for digital services have increased significantly.
- they are concerned about the impact on substance mis-users due to drop in face-to- face contacts and the limitations of digital services. For example, some substance use services have seen a 60% increase in incidences of self-harm.
- they continue to support high risk clients through face to face support and are maintaining support for some clients, when previously we might have moved on from services.

31. The pan-London homeless drug and alcohol service developed during pandemic is judged to have been successful. **By bringing together treatment providers in the capital and so providing a single of contact for professionals, it has facilitated collaborative working in the context of the previous fragmentation and competition that proved a barrier for those people accessing services**.

Wellbeing, Safety and Capacity of Workforce and Volunteers

32. **The absence of unambiguous, consistent and applicable operational guidance from government depts and ALB's that is relevant for service users and service contexts has been problematic**. Many providers have had to produce their own operational guidance to satisfy and comply with their own risk management and assessment arrangements and to keep services safe.

33. A priority concern for both commissioners and providers is, of course, **the imperative to respond to PHE's rapid review into disparities in risk and outcomes of COVID-19-as both a service provider for BAME people and communities (and for many) employers with a significant number of BAME staff**. This is particularly so in mental health and related sectors, which have relatively large numbers of BAME employers. A clear message from those staff concerned is that action and systemic change is now required and expected.

[3] https://www.ippr.org/files/2018-10/1540372212_fair-funding-for-mental-health-october18.pdf

34. At an operational level, there are challenges on **return to work arrangements for BAME staff at greater risk of C19** (particularly for those with frontline, client facing roles). One VCSE provider reports of a commissioning Trust which is not permitting its own BAME staff to return to client facing work, yet some BAME staff working for the provider have expressed a preference to return to work and do not wish to be 'treated differently'. **This example highlights both the moral and operational imperatives for individualised risk assessments, as a part of an integrated approach to addressing inequalities and promoting parity of esteem across the social care and health workforce (during the pandemic and beyond).**

36. Some providers report the **biggest decline in the mental health of service users has been within supported housing services (**and not in care/nursing home settings) with people disconnected from families, in addition to not being able to access usual support. Safeguarding concerns and incidents have been more prevalent in these settings, with the lack of support from specialist services/other agencies who would normally have stepped in (particularly around care co-ordination) particularly evident and with worse outcomes for services users. As a result, staff have been required to deal with a much higher level of anxiety and distress in what might be considered low level support services.

36. The **relative low-income status of the workforce** means that for many staff, public transport is their primary means of travel, bringing with it both real and perceived increased risk of infection and associated anxiety. Many staff have requested longer and less frequent shifts to avoid commutes. Whilst providers have endeavoured to accommodate such preferences and to strike a balance through consultation, long shifts are not always beneficial for employee wellbeing or the ability to provide the most effective support to clients.

37. In addition, staff with many providers continue to take on double and or long shifts, in order to avoid the use of agency staff to avoid introducing new staff to the services and so provide continuity of care and help mitigate, as far as possible, the risk of infection. Inevitably the result, however, is an increasingly tired

37. **In recognition of the potential longevity of C19 and its impact, the provision appropriate PTSD psychological other, additional practical support for staff will be an essential requirement moving forward, to maintain their wellbeing, build resilience and keep services stable and safe.**

38. Providers experience of accessibility to PPE and the adequacy of infection control-measures designed to protect staff and service users been mixed. Some Local **Resilience Forums have engaged and worked effectively with mental health service providers, others have not** and very different approaches to infection control across LAs have compounded difficulties in some areas. Similarly, whilst the Infection Control Fund given to LAs worked well in care home provision, supported housing/independent living sectors have not benefitted, so leaving both service users and staff exposed to greater infection risk.

39. Whilst the introduction of the NHS PPE portal has had a positive impact, it's essential that there is confidence in this being readied for any second wave. Accessing testing for service users at the onset of C19 in the early days was difficult

and whilst ostensibly the arrangements have improved, some providers now report people discharged from A&E into services with no screening.

40. The **continued uncertainty, as a result of local infection spikes and consequent lockdowns and the recently announced requirements for 14 days quarantine** for people returning from holidays in some destinations, remains. The latter is likely to increase the potential for gaps in staffing and continue to make it difficult to plan for and provide service continuity.

41. A number of providers continue to express **concerns as a result of the expectations from some commissioning bodies of a return to face to face work, often in circumstances where evidence and intelligence indicates that alternative means (e.g. remote, digital) remain both the safest and effective ways of keeping people safe and well** during the pandemic.

42**.** The **managed, incremental re-introduction of (if necessary, blended) services, informed by providers' assessments of what is feasible and safe given local circumstances and the needs and preferences of service users and the wellbeing of all staff (whether in statutory sector or independent and VCSE sector) is essential.** There is a need to guard against and challenge the assumption that carte blanche resumption of services to a pre-C19, face to face delivery format is in the best interests of all service users. It is also necessary to recognise the **risks associated with a cycle of re-introduction and withdrawal necessitated by any local lockdowns-or indeed the necessity for a second national lockdown.**

43. **The effects of C19 on staff and their own health and wellbeing has inevitably impacted on therapeutic relationships with people who use or need services**. This needs to be factored into practise considerations moving forward, in addition to the impact on those therapeutic relationships of remote working and digital access.

44. A more explicit recognition that staff are also community members and local citizens is required. Additionally, they may be either existing or prospective service users and are likely to have caring responsibilities for clinically vulnerable family members. They may also continue to be also be at greater risk of C19 themselves, as a result of socio-economic status and ethnicity.

45. This recognition needs to be reflected in the commissioning intentions and actions of local mental health and wellbeing services, by both the NHS and local authorities, through their adult social care and public health functions and in their community leadership roles. Such an approach would be consistent with the principles set out in the Social Contract for a Mentally Healthier Society[4], where every agency is seen as an equal partner during this crisis and beyond and recognising that VCSE providers and workforce are often working with most marginalised service users and those most at risk.

46. Maintaining stability and continuity in mental health and wellbeing services and keeping people safe, also requires recognition of the key role of mental health social workers (MHSW's) and approved mental health professionals (AMHPs) in implementing the statutory responsibilities of local authorities within mental health

[4] https://amhp.org.uk/app/uploads/2020/06/A-New-Social-Contract-for-a-mentally-healthier-society-FINAL.pdf

services. This also includes working within the NHS, VCSE and independent sector, where MHSWs lead on ensuring the social model of mental health is included within integrated services. The role of MHSWs has, of course, been affected by different approaches to integrated and joint working arrangements across the country. AMHPs services have been under considerable demographic and work pressure for some years (Skills for Care 2018 and 2019[5]) and **we recommend action to stabilise and support this workforce in line with the AMHP workforce plan (DHSC 2019[6]).**

47. The NHS facilitated Volunteer Responder Programme and the Social Work Together' and social care volunteering programme has clearly identified the readiness of significant numbers of citizens willing to give their time to help meet the needs of people who have been shielding during the pandemic, including latterly people with mental health challenges. This includes qualified staff who have left work and volunteered to return. However, the Advisory Group is aware that maximising the potential of volunteering to promote health and wellbeing, is often best achieved when part of local community led approach. Likewise, the engagement of volunteers in supporting people with mental health challenges has been most successful during the pandemic (as indeed it was prior), when part of locally funded and enabled volunteer mobilisation, where appropriate support and training can be provided, via established local VCSE organisations and related infrastructure bodies and in ways that complement existing the volunteering capacity of local mental health and wellbeing charities.

48. People with lived experience of poor mental health have highlighted to the Advisory Group **the critical role played by unpaid and family carers in helping to keep them safe and well during the pandemic to date.** Whilst some services report an increase in new referrals and carers returning to access services others working with and for **carers** report a **significant drop off in referrals**, despite the fact that they are aware of increasing need for help and support-much of which is not immediately visible.

49. The **limitations of digital and remote service have been particularly evident in services for carers**, where most want people have indicated they need face-to-face support and not in their own homes via digital means and in the presence or close proximity to the person for whom they are caring.

50. **Guidance designed to ensure that commissioning and services identify carers of people with mental health problems and respond accordingly must recognise that**:

- C19 will have 'hidden' carers even further from those statutory services (i.e. councils) responsible for assessing and meeting their needs.
- there is a need for clarity in messaging and information that a) carers are entitled to statutory support and b) where they can go to request that support.
- many carers have similar experiences to those with lived experience

5 https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/AMHPs-Briefing.pdf

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843539/AMHP_Workforce_Plan_Oct19__3_.pdf

- C19 is likely to have caused an increase in the mental health needs of some people and so increased the impact on carers-particularly those new to the role, as a result of the pandemic.
- In addition to restricting access to support (e.g. respite) for carers, C19 has revealed existing gaps in services for them around accessing and communicating with services, often in the context of paused (or 'redundant care plans) carers will have to deal with this accordingly
- many carers are providing support 24/7 to some people; others have been told they can't see the people for whom they care e.g. those in secure services.
- reasonable adjustments to working patterns will be necessary for those carers returning to work.

51. Planning for support and services for the next phase of the pandemic provides the opportunity to respond differently and more effectively to carers needs. **The lived experience of carers must be central this, drawing on their experience of what is effective and necessary. Similarly, a more nuanced approach to what is on offer from providers, in the form of outcome focused, person-centred services, should be enabled and expected by commissioners.**

Other Strategic Considerations

52. Official communications that have conveyed the **sense that C19 restrictions would be short term and that services and 'life' would return to pre-C-19 within relatively short period of time, have impacted on both service users and the wider population**. This is likely to continue to present challenges for services and providers who may not be able to meet those expectations in terms of a) service delivery and b) the increased demand for services in a society where C19 remains present and restrictions continue.

53. Again, there are issues here for the efficacy of Public Mental Health and other C19 messaging, which has been premised on the language of recovery and a projected 'return to normality'. **Reframing, based on the need for adaptation, flexibility and helping people and communities to live with ongoing uncertainty of C19 may be more beneficial in terms of a) psychological resilience and b) may result in more effective commissioning and service delivery options.**

54. Greater **equity in the accessibility and provision of services also requires recognition of the critical role played by local authorities, through their responsibilities for adult social care**, **in supporting and resourcing a capable VCSE mental health and wellbeing provider sector.**

55. **The effects of C19 on staff and their own health and wellbeing has inevitably impacted on therapeutic relationships with people who use or need services**. This needs to be reflected in effective practise development, in addition to the impact on those therapeutic relationships of remote working and digital access.

56. **Finally, the Advisory Group believes it is important that future policy and planning assumptions are not based entirely on the experience of last four-plus months,** given the dynamics of C19 and relatively limited nature of the

fluid and incomplete evidence base. **Vigilance, adaptation along with ongoing and meaningful engagement with people who use and need services** and those organisations who work most closely with them, is key to effective planning and commissioning of services and support moving forward.

Terms of Reference and Membership

The purpose of the group is to identify and provide advice to government, relevant bodies and partners e.g. CQC, local authorities and providers on:

- the strategic priorities for social care and support services for people with mental health and relevant other needs e.g. alcohol and substance misuse; and

- the priority actions-and those responsible for these-necessary to maintain stability in those services, ensure they remain accessible and keep people safe.

This work is required to help national and local mental health and care systems to:

- adapt and respond to the ongoing impact of C-19 on the mental health of people and communities;

- build and embed positive practise by and partnerships between commissioners and providers evidenced in the pandemic to date; and

- enable planning effective planning for services for the coming months, into winter 2020/21 and beyond.

The group work will consider these issues as they primarily (but not exclusively) relate to:-

- Implementation of the Social Care action plan: https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan

- Community Mental Health Framework for Adults and Older Adults: https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

- NHS England Operational Planning and Contracting Guidance 2020/21 https://www.england.nhs.uk/wp-content/uploads/2020/01/2020-21-NHS-Operational-Planning-Contracting-Guidance.pdf

- Implementation of the Care Homes Support Package: https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package

A working assumption is that the Advisory Group will cover all settings, including people's own homes.

The group will be required to pay specific attention to issues in relation to inequalities in mental health, particularly those experienced by BAME people, during C-19.

Working methods and output

- The group expects to hold four virtual meetings, as follows:
    - 15 July, 14:00-16:00
    - 22 July, 14:00-16:00
    - 29 July, 14:00-16:00
    - 5 August, 14:00-16:00
- The meetings will be held in private but there will be a public record of the main points of discussion at meeting.
- The final output from this group is expected by 7th August 2020.
- The Department of Health and Social Care will provide the secretariat for this group.
- The co-chairs will seek to work with other advisory groups, to ensure the to gain expertise and avoid duplication.
- The group's conclusions and advice will be conveyed in a short report of no more than 4 pages, which will then be translated into slides, for ease of presentation to wider audiences.

Impact of C-19 on people with mental health and related care and support needs

Qualitative experience of people who use or need services and carers.
Social distancing and increased digital and remote access.
Quantification, mapping of increases in nature of service demand e.g. anxiety disorders.
Effects a) on mental health of service users and b) at a population level.
Data use for national and local level planning.
Inequalities in access and outcomes, particularly re BAME people and communities.

Impact of C-19 on mental health and wellbeing commissioners and providers

Service demands, patterns and flows.
Provider leadership, strategic collaboration and readiness e.g. service re-configuration and system oversight.
Commissioning, contract management and operational contingencies e.g. in the light of need for ongoing infection control; variances in operating conditions in local communities.
Remote working, service offers and digital.
'Recalibration' of responsibilities for care-ordination, risk management and assessment; safeguarding; duty of care etc.
Strategic approach to integrated funding of and planning for care and support capacity for local mental health services, for the next 12 months and beyond, to maintain stability and keep people and communities safe.
Guidance for and clear expectations of commissioning in local systems to ensure equity of access to services.

Wellbeing and capacity of workforce and volunteers

PPE and maintenance of infection control measures.
Review of C-19 response re workforce capacity and competency, including additional or new effective practise skills, training and competency requirements.
Psychological support, PTSD, bereavement support.
VCSE and independent provider mental health and wellbeing offer for wider health and care workforce and system.
Recognition, status and perception; appreciation and reward.
Review approaches to risk assessment, including for those at higher risk/shielding (NB: there is a separate Advisory Group for this).
Addressing needs and concerns of BAME staff and volunteers.

Agreeing advice and recommendations

Review and confirmation of final report.

Membership

Caroline Allnutt, DHSC
Julie Bass, CEO Turning Point
Linda Bryant, CEO, Together for Mental Wellbeing
Jabeer Butt, CEO, Race Equality Foundation
Stephen Chandler, Corporate Director of Adult and Housing Services, Cherwell District Council and Oxfordshire County Council
Fazeela Hafejee, ADASS
Teresa Jennings, CEO, n-compass
Jane Hughes. CEO, Mental Health Matters
Sarah Hughes, CEO, Centre for Mental Health
Dr Sri Kalidindi, Consultant Psychiatrist in Rehabilitation and Recovery, SLaM NHS Foundation Trust
Viral Kantaria, Senior Programme Manager, Adult Mental Health Mental Health Team, NHSEandI
Lisa McNally, Director of Public Health, Sandwell MBC
Karen Machin, Independent Survivor Researcher
Katie Norton, Local Government Association
Clare Perkins, Deputy Director, PHE
Kathy Roberts, Association of Mental Health Providers
Isaac Samuels, National Co-Production Advisory Group
Kathy Smethurst, DHSC
Duncan Tree, Association of Mental Health Providers
Mark Trewin, DHSC
Mark Winstanley, CEO, Rethink Mental Illness

The group will be co-chaired by Kathy Roberts, CEO, Association of Mental Health Providers and Stephen Chandler, DASS, Oxfordshire CC. Secretariat will be provided by colleagues at DHSC.

Members of the Advisory group may appoint a deputy to attend in their place, if they are unavailable. The co-chairs may invite other stakeholders with specific areas of knowledge to attend one or more meetings, to provide relevant advice, as required.

Other areas of expertise

The co-chairs may invite specific expertise for one or more meetings from:

- Mental Health Providers Business and Service Continuity Planning Working Group
- Members of other Advisory Groups and the Task Force
- Office of the Chief Social Workers
- Health Education England
- Skills for Care
- Department of Work and Pensions
- Ministry of Housing, Communities and Local Government
- Care Quality Commission
- NHSE&I C-19 Homelessness Response Advisory Group