SUPPLEMENTARY AGENDA

NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday 29 January 2021, 10:00 a.m.
Remote meeting – MS Teams (watch it here)

Contact: Fiona Rae / Robert Mack

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Councillors: Alison Cornelius and Linda Freedman (Barnet Council), Larraine Revah and Paul Tomlinson (Camden Council), Christine Hamilton and Edward Smith (Enfield Council), Pippa Connor and Lucia das Neves (Haringey Council), Tricia Clarke and Osh Gantly (Islington Council).

Support Officers: Tracy Scollin, Sola Odusina, Andy Ellis, Robert Mack, and Peter Moore.

AGENDA

7. POST-COVID SYNDROME PATHWAY (PAGES 1 - 10)

This paper provides further information on the Post-Covid Syndrome pathway.

8. MENTAL HEALTH UPDATE (PAGES 11 - 22)

This paper provides an update in relation to Mental Health Services.

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Post-Covid Syndrome pathway and implementation update

JHOSC January 2021

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Demand (as January 2021)

How many people are affected?

This table and modelling is adapted from NICE guidance: Managing the long-term effects of Covid-19
We are currently revising these figures for January 2021.

Category of need	Barnet (pop 396k)	Camden (pop 262k)	Enfield (pop 338k)	Haringey (pop 271k)	Islington (pop 240k)	Proposed NCL model
Diagnosed cases	6,558 (Nov) 24,771 (Jan)	3,362 (Nov) 11,734 (Jan)	5,768 (Nov) 25,509 (Jan)	4,033 (Nov) 17,433 (Jan)	3,370 (Nov) 12,619 (Jan)	
People who were unable to work for up to 3 weeks because of Covid	3,960	2,620	3,680	2,710	2,400	Primary Care
People with chronic Covid, who haven't recovered within 12 weeks	1,980	1,310	1,690	1,355	1,200	Primary Care Community Team Acute Clinic
People with serious debilitating Covid, not able to take part in normal family life	396 (Nov)	262 (Nov)	338 (Nov)	271 (Nov)	240 (Nov)	Specialist Clinic Community Team

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What sort of need?

NICE definition for post-Covid syndrome – “Signs and symptoms that develop during or following an infection consistent with Covid-19 which continue for more than 12 weeks and are not explained by an alternative diagnosis. The condition usually presents with clusters of symptoms, often overlapping, which may change over time and can affect any system within the body. Many people with post-Covid syndrome can also experience generalised pain, fatigue, persisting high temperature and psychiatric problems.”

Post-Covid syndrome is a distinct condition. People experience a range of fluctuating symptoms including

Persistent and fluctuating fatigue	Breathlessness	Cognitive blunting “brain fog”	Pain	Anxiety and depression

What do we know about patient experience nationally?

The following experiences were taken from an Oxford series of interviews with over 100 patients experiencing Long Covid

- Can feel dismissed – patients are told there’s nothing wrong with them or are anxious, particularly if no positive test
- Experience fragmented care – e.g. specialist services can confirm ‘no heart attack’
- Find it hard to access appropriate rehabilitation
- Need to be persistent to organize appointments and access care

The appropriate community response will likely require co-ordination across rehabilitation and long term condition tea
working alongside mental health colleagues.

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Post-Covid pathway commissioning guidance

(10 December 2020)

Key Nomenclature – Post COVID terminology

Post COVID-19 Pathway: Inclusive of acute, ongoing symptoms and post COVID as per NICE definition and irrespective of discharge from an acute trusts, previous positive SARS-Cov-2 serology or clinical diagnosis in the absence of a clinical test.

Post COVID Syndrome: Signs and symptoms that develop during or following an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis

Post COVID Syndrome Pathway: Describing the patient pathway from presentation with symptoms aligned with Post COVID Syndrome to, and including, referral to onward support and self-management and a loop back into the MDT services

Key Nomenclature – multi-disciplinary team (MDT) terminology

Integrated Post COVID Follow-on Service MDT "Single Point of Access" - This is the multidisciplinary gateway service into follow on rehabilitation and community services. The single point of access service would act on the trusted assessment from the specialist assessment clinic and provide navigation into local rehabilitation assets, which they would have a role in curating taking account of local service configuration. Follow on services should include physical, mental, neurocognitive and social integration.

Post COVID Specialist Assessment MDT Clinic "Specialist Assessment Clinic" The specialist assessment clinic is part of the network of designated sites delivering to the national specification and funding. This includes access to diagnostic, functional, psychological needs and physiological assessment. This is a multidisciplinary specialist clinic as defined in the national commissioning guidance providing personalised care plans and trusted assessment for primary care and referral to single point of access services to access rehabilitation services.

Post-Covid syndrome – high level pathway

Patients identified in Community (proactive case finding by GPs focused on vulnerable groups

Patients identified following acute episode

Primary Care

Face to face assessment including vital stats, sit to stand test, respiratory exam, anxiety and depression screening, nervous system assessment, functional assessment, social, financial and cultural circumstances. Consider rehab referral or referral to NCL Post-Covid Clinic. Support to self manage using *Your Covid Recovery* resources.

Community Offer

Community rehabilitation including necessary fatigue and breathlessness management. Input from specialist community nurse (where available). Consider referral to NCL Post-Covid Clinic if appropriate.

NCL Post-Covid Syndrome Clinic

3 clinics weekly. Aim for initial face to face assessment for diagnostic tests and for doctor and physio review and then remote follow-up where possible. If needs ongoing physio assessment/ input or complex then further face to face arranged. Weekly MDTs with therapies, cardiology and neurology. Some joint clinics where needed. Referral onwards to other hospital specialties as required.

NCL Post-Covid Syndrome MDT

Attendees: GP, NCL Post-Covid Consultants, Care Navigator, Community therapists, Specialist Community nurses, psychology

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Model settings

Sector / Provider	Offer	Cohort	Geography / referral pathway
UCLH	NCL Post-Covid Syndrome Clinic (to manage post-Covid syndrome)	Complex Post-Covid Syndrome symptoms requiring specialist, multi-disciplinary support for people who have ongoing Covid related needs. In reach from Community and Primary Care	Pan NCL Referrals from Primary Care, Community or Acute
All community providers	Co-ordinated Community rehabilitation	Integrated offer linking rehabilitation and mental health services for both Post-Covid Syndrome cohort and people who have been discharged after a Covid related admission. Case management through UCLH app	Borough based Referrals from Primary or Acute or NCL Post-Covid Syndrome Clinic
All acute sites	Post covid clinics (upon discharge)	Post discharge support for all patients following covid related admission. **Some of these patients may require referral to NCL Post-Covid Syndrome Clinic.** Can refer on to community or discharge to primary care	Post discharge or referral only
General Practice / primary care network	Long covid support	Registered cohort Agreed pathway to community or direct to specialist clinic Option to refer to local acute if single specialty input needed	Borough based Practice cohort
NCL GP Federations	NCL Covid-19 Support Service	Service offers acute Covid clinical support to primary care GPs, remote telephone triage and home visiting for patients (there will be no face-to-face at either site in this phase).	Operating from 2 sites across Pan NCL

An integrated, equitable service

Presenting an integrated service

- This service will provided integrated care to patients including provision of specialist resource from community and hospital sites to patients in the community through the MDT model
- Also need to acknowledge potential service demand, and capacity amongst specialist respiratory and rehab services
- We will ensure that the service is presented to providers and patients in a way which reflects this to inspire confidence that all patients will have access to the care they need, even if they are not being physically seen in a specialist clinic

Managing health inequalities

- This service has been developed against the background of well-known health inequalities caused and exacerbated by Covid-19
- Post-Covid services have developed organically to date – creating additional geographic inequalities within NCL
- Creating a standard integrated care pathway which shares expertise from specialist centres across NCL will help us to reduce inequalities
- Proactive casefinding by GPs working with local partners will also help to identify and treat unmet need

Developing the Post-Covid syndrome multi-disciplinary team (MDT)

MDT-working design

- Steering group meeting fortnightly since November 2020 with representation from the whole pathway and all NCL boroughs
- Created a best-practice pathway for co-ordinated patient care between primary care, community and hospital settings
- Guidance for primary care in final draft with approval from LMC – practices will be able to draw on the GP Capacity Fund to resource case-finding, assessment and multi-agency working
- Borough-based MDTs will support primary care clinicians, and provide expert input into complex and ongoing cases

Camden Post-Covid Syndrome MDT

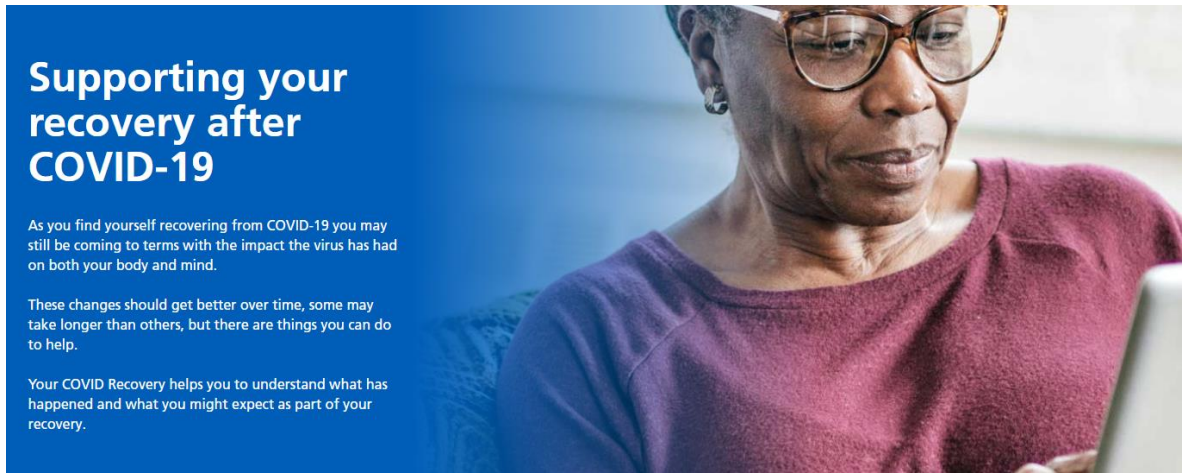
- Virtual MDT tested with primary care, UCLH, CNWL and mental health input
- Continues to be iterated and tested again based on attendee feedback to ensure best value for people's time and to create a spreadable model for consistency in NCL
- Plan to begin spreading to other NCL boroughs from January onwards beginning with Whittington Health
- Identifying ongoing primary and community development needs and resource required to deliver a regular service.

Supporting self-management

Your Covid Recovery

Online portal for self-guided recovery – encouraging primary care to refer patients to self manage online where appropriate.

https://www.yourcovidrecovery.nhs.uk/



Voluntary sector offers

- Connecting people to voluntary sector organisations who can provide support with post-Covid Syndromes including English National Opera, yoga and smell training."

- We are working with NHS charities on how best to use charity funding to support patients with post-Covid syndrome, with a focus on digital inclusion and health inequalities.

Next steps

1. Launch primary care post-Covid guidance with primary care including supporting resources (EMIS templates, screening tools, referral forms etc.)
2. Post-Covid syndrome teaching webinar for primary care 26 January
3. Scale up post-Covid MDT to all NCL boroughs
4. Ongoing monitoring of service capacity and training needs to ensure a high quality service offer in all boroughs
5. Continue to work with voluntary sector and NHS charities to create a broader community offer to residents

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North Central London Joint Health Overview and Scrutiny Committee
29 January 2021

Mental Health Update

Jinjer Kandola
NCL Mental Health Lead and
Chief Executive, BEH Mental Health NHS Trust

Introduction

- This morning will cover:
  - Current position on COVID-19 response
  - Transformation of services through the pandemic
  - Plans for further transformation of mental health services
  - Reducing inequalities
  - Moving to system based working in planning and delivering services
- Time for questions and discussion at the end

Current position

- Well prepared for latest wave and had all the necessary plans in place
- Priority is keeping patients and staff safe and supported
- Differences in latest wave are:
  - New variant is more transmissible – with higher prevalence
  - Major patient and staff COVID-19 vaccination programme – all Enfield care home residents and staff now vaccinated and 40% of BEH staff, increasing rapidly
- All efforts currently focused on COVID-19 response and future recovery

Current challenges

- Demand for acute mental health support has not reduced significantly in current wave, as it did in first wave
  - Mental health referrals not been materially affected by current lockdown
  - c. 20% decrease in Crisis Team face to face appointments but c. 10% increase in telephone contacts since mid Dec due to lockdown
  - Enfield Community Services referrals have reduced since mid Dec
  - 50 – 70 mental health inpatients with COVID at any one time (BEH + C&I)
- Reduced mental health bed capacity due to infection measures needed during current COVID wave
  - 25 - 40 beds closed at any one time to manage infections (BEH + C&I)
  - Resulting in 15 – 30 out of area placements at any one time (BEH + C&I)
- Staff absences due to COVID infections / self-isolation
  - Average 7% staff absences, compared to normal c. 4%, however, absences in specific teams / wards up to 11%

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Transformation of services through the pandemic

Supporting service users

- Minimising spread through tight infection control and cohorting inpatients
- Vulnerable patients being supported in the community
- Single Point of Access for referrals to each Trust, inc children and young people

Supporting staff

- All Trust staff receiving COVID vaccinations ASAP
- Supporting staff through regular communications, support helplines, relaxation spaces, psychological support
- Supporting BAME staff and others at higher risk

Transformation of services through the pandemic

Innovating services

- Increased virtual consultations for patients, where clinically appropriate and possible – but face to face still important
- Using digital technology to support more flexible working for staff
- New ways of working to support social distancing

Working in partnership

- Supporting acute hospitals, including A&Es
- BEH providing increased local physical health bed capacity on Chase Farm site to support discharge of patients from acute hospitals
- Redeploying staff to areas under most pressure

Future plans

We have learnt a lot from the pandemic and are embedding positive changes to improve services:

- Continued use of virtual consultations
- Better support for staff
- More flexible workforce roles
  e.g. Peer Support Workers
- More flexible staff working and use of our estate
- Working more closely across NHS, Council and voluntary sector partners

Future plans

- NHS Long Term Plan commits additional investment to mental health services
  - £18m new mental health service developments in 2020/21
- NCL following national NHS strategy to focus investment on expanding capacity of community mental health teams and Crisis Houses / Cafes
- National and NCL strategy is to reduce need for admission to a bed unless clinically necessary and ensure patients can be admitted to a bed locally
- With investment in alternatives, can manage this within current bed base
- NCL plans also seek to ‘level-up’ investment, so outer London boroughs receive proportionally greater share of new investments

Future plans

- Transforming community mental health services:
  - Increasing capacity of teams – e.g. 100 new community team staff at BEH
  - Voluntary sector being commissioned to provide additional support
  - Will avoid many patients going into crisis through better support earlier
- Strengthening Crisis Houses/Cafes in each borough:
  - Changing clinical model to focus on being a better alternative to admission rather than about supporting ‘step down’ from a ward
  - Increasing capacity, with more Crisis House staff,
    5 more beds in Haringey and new Crisis House in Camden

Reducing inequalities

- COVID-19 has highlighted health inequalities, major aim of future plans is to reduce inequalities
  - e.g. reduced life expectancy of c. 10 – 15 years of people with serious mental health conditions
- Supported by strengthened population health management to:
  - Analyse public health data and identify specific gaps / health inequalities in provision in specific populations / communities
  - Focus investment to specific improvements in services and outcomes
- NCL Mental Health Trusts now have dedicated Equalities, Diversity and Inclusion Lead, to address inequalities in patient care and for staff

Collaboration and system based working

- Nationally, NHS is increasingly working in Integrated Care Systems (ICSs) with local Integrated Care Partnerships (ICPs) at borough level
- NHS providers across NCL are working much more collaboratively, informed by the COVID-19 response and need to deliver integrated care
- For mental health, this means plans for future developments of services are being managed at NCL level

Summary

- NCL mental health services are responding well to current wave of COVID-19, but face significant challenges
- Pandemic has led to many beneficial changes in how services are provided, which will be maintained going forward
- Future plans are well developed for strengthening local mental health services further, through additional investment over next 3 years
- Health and care services are increasingly working together to provide better, more integrated care at local level and address health inequalities