Response to Health, Social Care and Sport Committee: Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales

Written Evidence from the Royal College of Psychiatrists Wales

For further information, please contact:

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The Royal College of Psychiatrists in Wales (The College) is the professional medical body responsible for developing and supporting psychiatrists throughout their careers, and in setting and raising standards of psychiatry throughout Wales.

The College aims to improve outcomes for people with mental disorders and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations.

The Royal College of Psychiatrists Wales is pleased to respond to this inquiry. In determining a response, we have highlighted 2 initial areas, alongside a comment on recovery planning. The College would be very happy to provide any further evidence to the committee, in writing or virtually. Our areas:

- Delivering core NHS and care services during the pandemic and beyond,
- Coronavirus and the impact on people with protected characteristics.

Delivering core NHS and care services during the pandemic and beyond

While COVID-19 is a virus, it is having a profound impact on the nation's mental health. If there is a post Covid-19 recession, the economic downturn will have significant implications for the nation's mental health and suicide rates.

The virus is also affecting the mental health and well-being of NHS and social care staff. The ONS has reported a sharp rise in the number of people reporting high levels of anxiety and our survey of psychiatrists has found that there has been an increase in the number of urgent and emergency cases seen by psychiatrists.

Our recent surveys of psychiatrists (15th-17th April and 1st-6th May) have also highlighted significant concerns that psychiatrists are being forced to put themselves and their patients at risk, delivering care without adequate PPE or access to tests for themselves, their families or their patients.

Our recommendations for delivering core services

- *Consistent message sent to the public that if you have a mental health need you should still seek help.*
- *Mental health services must be adequately supported to deal with the increase in urgent and emergency demands*
- *Expand and monitor efforts to ensure all staff working in mental health care get access to the PPE and COVID-19 tests they need.*
- *NHS Wales should closely monitor the implementation of the guidance on infection control and offer additional support to those areas that are struggling to follow them.*
- *Provide ongoing support to healthcare staff after the initial peak and give them support to recover before any potential second wave.*
- *Invest in expanded mental health services to cope with the likely rise in demand for services following the initial COVID-19 peak.*
- *Invest in support for the general population in the event of an economic downturn.*

How has demand for mental health services been affected by the pandemic?

Our survey of psychiatrists working in the NHS has found that the COVID-19 pandemic has led to an overall increase in emergency and urgent appointments and an overall decrease in the number of patients they have seen for more routine support:

- Emergency interventions/appointments - 13% have seen workload increase, 30% have seen a decrease
- Urgent interventions/appointments - 36% have seen workload increase, 32% decrease
- Appointments/interventions normally conducted within four weeks - 11% have seen an increase, 54% a decrease
- Appointments/interventions normally within three months - only 14% have seen an increase, compared to 39% seeing a decrease
- Appointments/interventions normally after three months - just 5.5% have seen this area of workload increase, compared to 51% who have seen these caseloads decline.

The decrease in non-urgent cases is as concerning as the rise in urgent and emergency cases expressed by some of our psychiatrists. It is much harder for mental health teams to deliver routine services while managing social distancing, dealing with an increase in urgent and emergency cases and supporting patients who may have COVID-19.

Psychiatrists report to us their concern that temporary drop offs in some activity represents a calm before the storm, due to some services being delayed and some patients avoiding contact due to fear of infection or concern that they are being a burden on the NHS. It is critical that people are aware that NHS mental health services are still open. Those who fail to get the help they need now, may become more seriously ill further down the line.

According to our survey, psychiatrists working with older adults have seen the biggest decrease in regular appointments. Over half of respondents stated that long term appointments have either decreased or significantly decreased since the crisis started. Unfortunately, this is not surprising considering they are the group most at risk from infection and have been advised to take extra precautions around isolating. It may also be that they are the group less able to engage with their mental health team via increasingly adopted methods of remote working such as online video calls. Although it is important not to generalise and assume all older people will be uncomfortable talking to a psychiatrist over the internet.

Our faculty of older adult psychiatry had reported restrictions on care home admissions. Although, this is for the safety of existing residents our psychiatrists are concerned for their patients with advanced dementia who need constant support and care but cannot be admitted to a specialist facility. Guidance on hospital discharge issued from Welsh Government has looked to address this challenge.

Our survey found that psychiatrists working in Liaison mental health, and General adult services have had the biggest increase in emergency appointments/interventions.

Psychiatrists are also reporting a significant drop off rate in regular referrals to child and adolescent mental health services. Far fewer children are being referred from primary care to mental health services. This is particularly concerning for patients with mental health conditions which have an increased mortality rate such as eating disorders, bipolar disorder and schizophrenia.

Some of our Forensic Faculty of psychiatrists working in secure NHS facilities and prisons have also expressed significant concerns about their ability to care for patients. They have faced a reduction in referrals and a reduction in the number of hospital patients they've been able to transfer to community services. It is particularly difficult to deliver services in prisons as many of our psychiatrists have struggled to access patients although we have had reports that this is improving.

Another area where our psychiatrists have expressed significant concerns is within addiction services. Our Addictions Faculty members have told us that some people with alcohol addictions problem are drinking much more and becoming even more chaotic in their lifestyles as a result of the pandemic. We have had reports of a significant number of people relapsing because of the strains of lock down and being cut off from their friends and families.

Many providers of mental health services reacted quickly to change the way services act in response for the crisis. Many psychiatrists are currently working an 'altered timetable' due to reconfiguration of services.

During the COVID-19 pandemic, it is essential that those who use mental health services continue to get the care they need. Remote consultations, using telephone calls, audio and video to provide care for patients has already become a fundamental part of the way mental health services provide care. As we move beyond the peak of the crisis, this is likely to become more standard practice and there are concerted efforts to continue to increase capacity.

Many psychiatrists are currently working remotely, showing that services are able to provide flexibility for staff as well as patients.

Those with a lack of digital literacy, lacking in confidence using technology or with little or no access to digital platforms must not be disadvantaged. Use of telephone consultations, rather than more complex video platforms may be sufficient for lower risk conversations or to ensure engagement with those who lack digital technology or skills.

The College has published online resources for people with a mental illness and their carers on issues such as medication and how to manage their conditions during the crisis.

Access to PPE

A pair of college surveys found that psychiatrists are being forced to put themselves and their patients at risk, delivering care without adequate PPE or access to tests for themselves, their families or their patients[1].

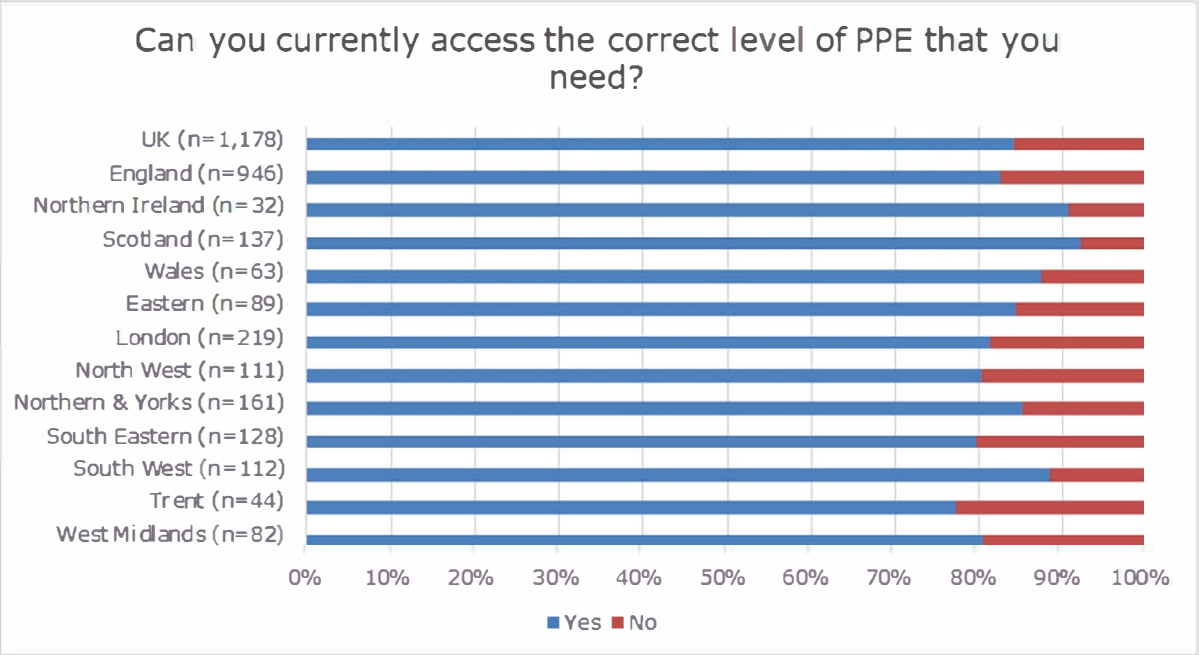
One psychiatrist surveyed said "There are extreme shortages of PPE and most of us are at risk. Only very limited supply is obtained and most of the time frontline staff are refused risking their lives. Staff are terrified and afraid."

Our latest survey (in the field from 1-6 May) has shown that a significant proportion of psychiatrists are concerned that they are not able to access the level of PPE set out in the guidance.

- Around 16% of psychiatrists in the UK don't have access to correct PPE.
- In Scotland this was 8%, Wales 13%, Northern Ireland 9% and 18% in England.

The national and regional breakdowns are as follows

Chart 1 - Are you able to access the following PPE kit when you need it (in line with the latest guidance from your organisation)? (NB – don't know responses were excluded)



Some of our psychiatrists have previously expressed concerns about the potential impact the lack of adequate PPE is likely to have. Some of the most concerning responses to our first member survey (in the field from 15-17 April) included psychiatrists saying that:

- *"Last week we did CPR on a patient who had hung themselves with no fit tested PPE."*
- *"There are extreme shortages of PPE and most of us are at risk. Only very limited supply is obtained and most of the time frontline staff are refused risking their lives. Staff are terrified and afraid."*
- *"Spitting in Covid positive patients is a real issue and not able to get the appropriate PPE, social distancing impossible in inpatient settings."*

Access to testing

The other major concern raised by our psychiatrists is that a significant proportion are unable to access tests for themselves, their families or their patients if they have concerns if they have COVID-19. The current Government guidance states that any NHS worker or their family member with suspected COVID-19 should be able to access testing and that tests should be given to any new patient entering an inpatient setting.

When our psychiatrists across the UK were surveyed (1-6 May) we found that, In Wales:

- Around one in ten psychiatrists working in the NHS said they were not able to access a test for COVID-19 for themselves if they had symptoms, if you include those who did not know if they could access a test it was up to almost a quarter.
- One in four either could not or did not know if they could access a test for their patients
- Almost a half (45%) could not or did not know if they could access a test for members of their household

Whilst these findings have improved since our first survey (15-17 April), there are still areas for improvement.

Infection control and prevention

The majority of mental health units in the UK were never designed to contain a highly contagious illness. Potential environmental risks include aged estates with a significant proportion of dormitory style accommodation, small shared offices, shared computers, shared patient facilities, sitting or dining rooms, shared toilets, poor ventilation and air-conditioning. Particularly worryingly last year there were 1,176 patients (UK-wide) having to share mixed dormitories[2].

In addition, it is often the case that some patients may be unable to follow advice on containment, isolation and testing, which presents a further clear infection risk to be considered and managed.

We are concerned that some NHS mental health estates are unsuitable, making it very hard to follow guidance. The guidance includes

recommendations that all new patients coming into a mental health, learning disability, autism, dementia or specialist inpatient facility are tested for COVID-19, including asymptomatic patients, and kept separate from other patients until they get their results back.

As shown above many of our psychiatrists have expressed significant concerns that they are currently unable to access testing for their patients. To date it has been very difficult to effectively cohort due to lack of adequate access to testing, therefore it is important that effective delivery of this change in testing policy in mental health settings is monitored and not overlooked.

Many sites also lack the space to keep patients separate especially those with mixed dormitories. Consideration is needed on how Health Boards can be supported to undertake the complex task of cohorting effectively within their estates, both in the immediate term and looking to the medium and longer term.

On admission, space is needed for confirmed COVID cases, a second space for patients confirmed via testing to be COVID negative and a third space patients whose COVID status is unconfirmed while test results awaited. In addition, patients who need shielding should be kept away from those with confirmed COVID.

It is important to understand the extent to which local areas are able to follow this guidance, and this is monitored, and additional support is offered to those areas that are struggling to follow them.

How we can we support the mental health of NHS staff?

At this time, NHS staff may feel stressed for many reasons such as having to make difficult decisions about patients' care, the amount of work, being uncertain about the future, worrying about taking the virus home with them and infecting others, and/or less contact with family and friends.

The role of NHS team leaders, managers and supervisors is crucial to ensure NHS staff have the mental health support they need. NHS leaders need to have frank discussions with staff about the challenges that lie ahead, not to sugar coat them but also not to overstate the trauma they are likely to face. These discussions should address the difficult decisions that staff may have to make.

We also recommend supervisors speak with their teams using structured forums similar to the ones provided by Schwartz Rounds. Such forums enable staff to come together with their leader after their shift and talk honestly about what did and didn't go right, the difficulties they faced and the associated emotional reactions. While staff will have limited time to be involved in such discussions, this approach is likely to reduce the potentially damaging mental health impacts of working on a stressful hospital ward. This should be done during staff's normal working hours.

For further information, we have published a range of resources for team leaders and supervisors as part of our COVID-19 guidance. We have also developed specific resources for psychiatrists on taking care of themselves as well as helping other healthcare professionals.

Despite the challenges they face during the pandemic, most NHS workers will not suffer from a mental illness. With good leadership, as well as properly preparing and supporting NHS staff, most will avoid developing longer-term difficulties.

For those who do need help, we should provide evidence-based care both in the short term to help NHS staff get back to work and in the long term. The available evidence strongly suggests that the support given to NHS staff members as the crisis begins to recede is of critical importance in determining whether they will experience psychological growth, develop a mental health disorder or neither.

Supporting the health and wellbeing of NHS workers following the first COVID-19 outbreak is likely to be even more critical. To this end, the NHS must give its staff members - who have been working intensively in arduous circumstances - sufficient time to 'reset' before they embark on their usual work.

This time will be crucial for them to access the social support they need, and to readjust to the 'new normal' without being under too much pressure while trying to recover. Should there be second wave of coronavirus this rest period will be even more crucial

We have developed some concrete elements that we believe should be put in place for staff in every NHS Health Board, including:

- Any staff member who unexpectedly does not turn up for a shift should be proactively contacted.
- Once someone completes their COVID-19 work they should be thanked, be provided with opportunities to informally mix with

their colleagues and given relevant mental health and welfare information.
- Workplace supervisors should carry out a structured return to post-COVID-19 work interview.
- Staff should be written to again three and 12 months [and possibly later] post completing their COVID-19 work and be given information about how they can check their own mental health.

How we can we support people's mental health after the initial peak?

It seems inevitable that once the pandemic is past its peak, there will be an increase in demand for mental health services and for support for the general population. That need will increase more if there is an economic downturn. This may be because of pent up demand caused by the current fall in referrals, the consequences of lockdown, economic uncertainty and the trauma of contracting or losing loved ones to COVID-19.

The recent ONS wellbeing survey found that between 20 March and 30 March 2020 almost half of the population of Great Britain (49.6%) reported high levels of anxiety. This compares to 21% of people who said the same last year[3].

A significant economic downturn following the crisis is widely predicted and there is strong evidence of a link between economic difficulties and higher rates of mental health problems and suicide[4]. We have already seen from the recent ONS survey that people who had experienced a reduction in household finances because of COVID-19 reported 16% higher anxiety on average[5].

Mental health services, which are overstretched at the best of times, will come under even more pressure. One of the biggest causes of this is a lack of trained staff.

In March, we released our manifesto for the 2021 Senedd Cymru elections. We highlighted particular areas of focus for developing the workforce in Wales that will support ambition, and it's essential that this is confirmed and commitments are made within the mental health workforce strategies that have been outlined within Welsh Government's 'Together for Mental Health Strategy'.

It is important that these commitments are not forgotten, and that recommendations from our manifesto are brought forward in working towards achieving parity between services; and respective of parity in developing parity for a mental health workforce.

Coronavirus and the impact on people with protected characteristics

Over a third of people with a severe mental health illness (37.6%) also have a long-term physical condition[6] meaning that they are disproportionately at risk of being affected by COVID-19.

In the UK, people from Black, Asian and minority ethnic backgrounds (BAME), face persistent and wide-ranging inequalities. An individual from a Black, Asian or minority ethnic background is more likely to experience poverty, to have poorer educational outcomes, to be unemployed, and to come in contact with the criminal justice system[7]. These, in turn, are risk factors for developing a mental illness.

Emerging data from the COVID-19 pandemic clearly shows that BAME groups are significantly more likely to die from COVID-19[8], the reasons for this are currently not well established, though societal inequalities are likely to play a role.

This submission focuses on what impact the crisis is having on mental health services and those services that are delivered to people with protected characteristics.

We have also looked to address the Coronavirus Act 2020 and the impact that will have on those with protected characteristics.

Recommendations to support people with protected characteristics

- *The emergency changes to the Mental Health Act should only be used where patients would otherwise be put at risk and their use should be closely monitored.*
- *The need for the enactment and prospective enforcement of the MHA emergency changes, should be closely monitored and justified – At present, we do not support a case for enactment and enforcement*
- *Health Boards should adopt the College guidance and work with individual staff to develop appropriate and robust risk mitigation for BAME mental health staff, and access to support should be readily made available and accessible.*
- *When the peak of the crisis is over mental health services should not go back to normal instead commissioners should learn from the National Collaborating Centre for Mental Health Advancing Mental Health Equality (AMHE) guidance when redesigning services*
- *When supporting patients during the COVID-19 crisis staff should use the least restrictive option that is possible*

The emergency coronavirus legislation and mental health

Schedule 8 of the Coronavirus Act creates the ability for changes to be made to mental health legislation across the UK. These changes have so far not been enacted apart from those related to the Mental Health (Northern Ireland) Order 1986 - in Northern Ireland.

The changes to the Mental Health Act 1983 (England and Wales) (MHA) would allow certain functions relating to the detention and treatment of patients to be carried out with fewer doctors' opinions or certifications. It also temporarily allows for the extension or removal of certain time limits relating to the detention and transfer of patients. Full details of what this would entail can be found on our website[9]

Although Black British adults had the highest mean score for severity of mental health symptoms, they were the least likely to receive treatment for mental illness. Where they do come into contact with services, it is disproportionately based on a detention order requiring them to stay in hospital[10].

If this legislation is enacted, it would disproportionately impact these groups. We are extremely conscious that enacting MHA emergency powers would weaken patient safeguards, so it is essential that their use must always be justified. People shouldn't be denied access to the care they need, and potentially left in a situation where their own life is at risk due to a lack of staff. If those needing care don't get it because of a depleted workforce it will further affect an already disadvantaged group and so on balance.

We have monitored the views of psychiatrists closely in relation to delays that may have been experienced in using the MHA in the last few weeks.

75% of psychiatrists had not reported trouble convening a MHA assessment in Wales, only 7% had (the remaining responders are not convening community MHA assessments during their work)

Presently we do not believe there is an evidence base to justify enforcement of the MHA amendments in Wales, should they be enacted by the UK Government.

Enacting the MHA emergency powers would weaken of patient safeguards. Therefore, their use would need to be justified every single time they are used.

If emergency powers are enacted, they should only be used where necessary and justifiable. It is essential that it is clearly communicated that the powers, if enacted they should not be used nationally, only where the lack of staff caused by the COVID-19 crisis means a patient's safety is being put at risk and where there is no alternative.

We are also very conscious that the MHA is currently applied disproportionately to people from some BAME communities.

RCPsych recognises that racism and racial discrimination is one of many factors which can have a significant, negative impact on a person's life chances and mental health. We are particularly concerned about the disproportionate impact on people from Black, Asian and minority ethnic communities, notably those of Black African and Caribbean heritage. It can lead to substantial disparity in access to and experiences of various areas of psychiatric care, including crisis care, admissions, pathways into care, readmissions, use of seclusion and detentions under MHA. [11]

We have highlighted our cautious position to Welsh Government.

In 2018 the RCPsych paper on racism in mental health[12] highlighted that although Black British adults had the highest mean score for severity of mental health symptoms, they were the least likely to receive treatment for mental illness. We repeat our calls that efforts to tackle this should be urgently prioritised by Government, non-governmental organisations and professional bodies.

Following this paper, the National Collaborating Centre for Mental Health based at the RCPsych published a document called Advancing Mental Health Equality (AMHE)[13] which is a resource to support commissioners and providers to tackle mental health inequalities in their local areas[14]. This document should be a key tool for mental health commissioners to plan how they should reshape their services as they adjust following the COVID-19 crisis, including how any use of remote consultations and other digital solutions are appropriately designed.

Additionally, The College has endorsed the Cultural Competency in Mental Health Services initiative that has been developed by Diverse Cymru, working closely in its development and in ensuring that every health board is working towards this standard.

Mental health services for older adults

A recent survey of RCPsych members has found that psychiatrists working with older adults have seen the biggest drop off in the ability to deliver regular appointments. With over half saying that long term appointments have either decreased or significantly decreased since the crisis started.

This is not surprising considering they are the group most at risk from infection and have been advised to take extra precautions around isolating. It may also be that they are the group less able to engage with their mental health team online. Although it is important not to generalise and say that all older people will not be comfortable talking to a psychiatrist over the internet.

Our older adult faculty has also reported restrictions on care home admissions. Although, this is for the safety of existing residents our Old Age Faculty is concerned for their patients with advanced dementia that need constant support and care but cannot be admitted to a specialist facility.

Equalities considerations on COVID-19 impact on healthcare staff

In response to emerging evidence on the disproportionate impact of Coronavirus on people from BAME communities, the government has set up a review into this issue. This disproportionate impact is also being seen in the healthcare system, with evidence emerging that disproportionate numbers of BAME healthcare staff are being affected by Coronavirus[15],[16],[17],[18]. In response to this, the President of the Royal College of Psychiatrists set up a Task and Finish Group to look into this issue, and develop recommendations for mental health services across the UK to help them support BAME staff, put risk mitigation processes in place, and develop longer term solutions to address inequality in the workplace.

The Task and Finish Group reviewed the evidence that currently exists on the impact of the virus on BAME healthcare staff, and has found that the disproportionate mortality of health and care staff from black and minority ethnic backgrounds during the COVID-19 pandemic is not fully explained by other suggested risk factors. This has an adverse impact on the entire mental health workforce and additionally involves further direct and indirect harm through longer term morbidity, physical recovery and psychological consequences of this unequal disease burden.

There are multiple risk factors associated with the increased impact of COVID-19 in the BAME health workforce, which include biological, medical, sociological and structural issues[19],[20]. WRES data also indicates that BAME healthcare staff are more likely than their white counterparts to experience bullying and discrimination in the workplace[21], and so therefore may not feel able to freely raise concerns.

This underpins the need to ensure that BAME colleagues are proactively supported by leadership and management during and after this crisis, for their security and the security of the future mental health workforce. In the short term, appropriate and robust risk mitigation for BAME mental health staff should be put in place during the COVID-19, and access to support should be readily made available and accessible.

In the longer term, recommendations on addressing inequalities within the health workforce and system must be implemented in a robust and

transparent manner and understanding of the value and strengths of a diverse mental health workforce acknowledged and communicated across the system. Furthermore, the longer-term psychological impacts of the COVID-19 pandemic on BAME healthcare staff may be significant and complex, and mental health service management should lead the way in ensuring support is adequate, available and accessible for those that need it.

The full report from the group identifies the need for a good, collaborative risk assessment that will enable robust risk mitigation to be implemented and support individual staff members to feel more confident about being protected at work while undertaking duties in the care of others.

We have shared with the Advisory Group that has been convened by Welsh Government and are keen that this recommendation is taken forward.

Reducing restrictive practices

People with a learning disability and/or autism in inpatient settings are already vulnerable to and disproportionately represented in the use of inappropriate and excessive restraint, seclusion and long-term segregation. Restrictive practices are also used disproportionately on those from ethnic minority communities, women and girls. [22]

During the pandemic services and staff are still required to commit to reducing their use of restraint. The only changes to patient care should be those needed to manage and prevent the spread of COVID-19. At every opportunity, they should consider whether there is a less restrictive option available to them. Any use of restraint must be appropriate, be proportionate to the risks involved and end as soon as possible. Providers should refer to their ethics committees where required and as always it is essential that all staff using restraint techniques are fully trained.

RCPsych has developed the COVID-19 Mental Health Improvement Network to support mental health teams to share and learn from each other to maintain and improve safety in response to the COVID-19 pandemic. It is working to identify areas where improvement packages are needed during this period, one of such areas is restrictive practice. A short "change package" is available, along with a series of webinars in order to support services in this area.

Once the initial crisis is over it is critical that learning from RCPsych's reducing restrictive practice programme is considered for wider roll-out across Wales. The initial pilots from England have demonstrated that with the right support health boards can significantly reduce how often they use restrictive practices.

Additional Comment

We have closely monitored the views of psychiatrists, patients and services during this time. It is important to recognise how the mental health workforce, alongside patients and carers have adjusted to the pandemic under significant pressure.

It does further highlight that there is not parity between physical and mental health, and that there is need to strategically invest to support some of the most vulnerable people in society.

It is essential that the College has direct contribution in how services will look to recover and prepare for a second phase.

We must all also ensure that planning considers opportunities that can be sustained, post COVID-19 and will continue to have an impact across the health service.

Once such consideration that the College would particularly choose to be highlighted and recognised, is the successful work of Technology Enabled Care Cymru (TEC Cymru). The rollout of telehealth and video consultation was informed from a pilot project 'CWTCH', for CAMHS services in Gwent. The pilot lead, Prof Alka Ahuja was subsequently seconded to Welsh Government as a clinical lead for TEC Cymru.

There are a number of additional innovations that stand to make a significant improvement to services, across the NHS as well as ensuring we work towards a parity between services. These are highlighted in our manifesto and we believe will compliment much of the Committees considerations that will inevitably arise from this inquiry, in considering what the Health & Social Care service could like in recovery and post

COVID-19. We would be keen to follow up and give further suggestion to the Committee.

As a final point, in this response.

40% of psychiatrists in Wales have reported that their mental health and wellbeing has suffered or significantly suffered during this time. Alongside the challenge presented by the nature of the virus; there is more that can be done to support the impact of a pandemic on mental health services, its patients and workforce. The College is well positioned to advise and reflect on the experiences of psychiatrists.

Our additional recommendations

- *That specialist mental health services have a direct voice within the recovery planning from Welsh Government*
- *That the impact upon the wellbeing of Psychiatrists (and its unique determinants as highlighted in this response) as well as the wider NHS and Social Care workforce is further examined by Welsh Government in partnership with the College.*

[1] The Royal College of Psychiatrists issued a survey to its members working in the National Health Service across the United Kingdom. It was in the field from Wednesday 15 April until the morning of Friday 17 April.

[2] https://www.hsj.co.uk/finance-and-efficiency/exclusive-hundreds-of-patients-kept-in-distressing-dormitory-style-wards/7025290.article

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personaleconomicwellbeingintheuk/may2020

[4] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-poverty

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personaleconomicwellbeingintheuk/may2020

[6] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-physical-health-conditions Raj, D., Stansfeld, S., Weich, S., Stewart, R., McBride, O., Brugha, T., ... & Papp, M. (2016). Chapter 13: Comorbidity in mental and physical illness. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digita

[7] Equality and Human Rights Commission, 2016, *Healing a Divided Britain*.

[8] ONS, Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020,

[9] https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/legal-covid-19-guidance-for-clinicians

[10] NHS Digital (2017) Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics

[11] Royal College of Psychiatry, Racism and Mental Health, 2018 https://www.rcpsych.ac.uk/pdf/PS01_18a.pdf

[12] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_18.pdf?sfvrsn=53b60962_4

[13] https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/advancing-mental-health-equality

[14] https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/advancing-mental-health-equality

[15] NHS confederation (2020) The impact of COVID-19 on BME communities and health and care staff. Available from: https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Impact-of-COVID-19-BME_communities-and-staff_FNL.pdf

[16] Health Services Journal (2020) Exclusive: deaths of NHS staff from COVID-19 analysed. Available from: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

[17] Kanani, Nikki. Issar, Prerana. (2020) Note for all BAME colleagues working in the NHS. Available from: https://www.england.nhs.uk/blog/note-for-all-bame-colleagues-working-in-the-nhs/

[18] Chakravorty I, Daga S, Dave S, Chakravorty S, Bhala N, Menon G, Mehta R & Bamrah JS. An online survey of healthcare professionals in the COVID-19 Pandemic in the UK. Sushruta 2020 (Jul) vol13(2): ePub 25.04.2020 (pre-print v1.2*) DOI: 10.38192/13.2.9

[19] Kings Fund (2020) Ethnic Minority Deaths and COVID-19: What are we to do? Available from: https://www.kingsfund.org.uk/blog/2020/04/ethnic-minority-deaths-covid-19

[20] NHS confederation (2020) The impact of COVID-19 on BME communities and health and care staff. Available from: https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Impact-of-COVID-19-BME_communities-and-staff_FNL.pdf

[21] NHS (2019) NHS workforce race equality standard: 2019 data analysis report for NHS trusts. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

Response to Health, Social Care and Sport Committee: Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales

Further Written Evidence from the Royal College of Psychiatrists Wales

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[redacted] Manager
[redacted]

The Royal College of Psychiatrists in Wales (The College) is the professional medical body responsible for developing and supporting psychiatrists throughout their careers, and in setting and raising standards of psychiatry throughout Wales.

The College aims to improve outcomes for people with mental disorders and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations.

We are pleased to be invited to present oral evidence to the Committee, and have accordingly provided additional written evidence in support, in this additional submission.

For ease, we have identified the initial written evidence that we provided for the Committee, whilst differentiating additional evidence.

Section One – Initial & Updated written evidence
Section Two – Additional thoughts and recommendations

Section One – Initial written evidence

The Royal College of Psychiatrists Wales is pleased to respond to this inquiry. In determining a response, we have highlighted 2 initial areas, alongside a comment on recovery planning. The College would be very happy to provide any further evidence to the committee, in writing or virtually. Our areas:

- Delivering core NHS and care services during the pandemic and beyond,
- Coronavirus and the impact on people with protected characteristics.

Delivering core NHS and care services during the pandemic and beyond

While COVID-19 is a virus, it is having a profound impact on the nation's mental health. If there is a post Covid-19 recession, the economic downturn will have significant implications for the nation's mental health and suicide rates.

The virus is also affecting the mental health and well-being of NHS and social care staff. The ONS has reported a sharp rise in the number of people reporting high levels of anxiety and our survey of psychiatrists has found that there has been an increase in the number of urgent and emergency cases seen by psychiatrists.

Our recent surveys of psychiatrists, at the earlier stage of the pandemic (15th-17th April and 1st-6th May) have also highlighted significant concerns that psychiatrists are being forced to put themselves and their patients at risk, delivering care without adequate PPE or access to tests for themselves, their families or their patients.

Our recommendations for delivering core services

- *Consistent message sent to the public that if you have a mental health need you should still seek help.*
- *Mental health services must be adequately supported to deal with the increase in urgent and emergency demands*
- *Expand and monitor efforts to ensure all staff working in mental health care get access to the PPE and COVID-19 tests they need.*
- *NHS Wales should closely monitor the implementation of the guidance on infection control and offer additional support to those areas that are struggling to follow them.*
- *Provide ongoing support to healthcare staff after the initial peak and give them support to recover before any potential second wave.*
- *Invest in expanded mental health services to cope with the likely rise in demand for services following the initial COVID-19 peak.*
- *Invest in support for the general population in the event of an economic downturn.*

How has demand for mental health services been affected by the pandemic?

Our survey of psychiatrists working in the NHS has found that the COVID-19 pandemic has led to an overall increase in emergency and urgent appointments and an overall decrease in the number of patients they have seen for more routine support:

- Emergency interventions/appointments - 13% have seen workload increase, 30% have seen a decrease

- Urgent interventions/appointments - 36% have seen workload increase, 32% decrease
- Appointments/interventions normally conducted within four weeks - 11% have seen an increase, 54% a decrease
- Appointments/interventions normally within three months - only 14% have seen an increase, compared to 39% seeing a decrease
- Appointments/interventions normally after three months - just 5.5% have seen this area of workload increase, compared to 51% who have seen these caseloads decline.

The decrease in non-urgent cases is as concerning as the rise in urgent and emergency cases expressed by some of our psychiatrists. It is much harder for mental health teams to deliver routine services while managing social distancing, dealing with an increase in urgent and emergency cases and supporting patients who may have COVID-19.

Psychiatrists report to us their concern that temporary drop offs in some activity represented a calm before the storm, due to some services being delayed and some patients avoiding contact due to fear of infection or concern that they are being a burden on the NHS. It is critical that people are aware that NHS mental health services are still open. Those who fail to get the help they need now, may become more seriously ill further down the line.

According to our survey, psychiatrists working with older adults had seen the biggest decrease in regular appointments. Over half of respondents stated that long term appointments have either decreased or significantly decreased since the crisis started. Unfortunately, this is not surprising considering they are the group most at risk from infection and have been advised to take extra precautions around isolating. It may also be that they are the group less able to engage with their mental health team via increasingly adopted methods of remote working such as online video calls. Although it is important not to generalise and assume all older people will be uncomfortable talking to a psychiatrist over the internet.

Our faculty of older adult psychiatry had reported restrictions on care home admissions. Although, this is for the safety of existing residents our psychiatrists are concerned for their patients with advanced dementia who need constant support and care but cannot be admitted to a specialist facility. Guidance on hospital discharge issued from Welsh Government has looked to address this challenge.

Our survey found that psychiatrists working in Liaison mental health, and General adult services have had the biggest increase in emergency appointments/interventions.

Psychiatrists also reported a significant drop off rate in regular referrals to child and adolescent mental health services. Far fewer children were being referred from primary care to mental health services. This is particularly concerning for patients with mental health conditions which have an increased mortality rate such as eating disorders, bipolar disorder and schizophrenia.

Some of our Forensic Faculty of psychiatrists working in secure NHS facilities and prisons also expressed significant concerns about their ability to care for patients. They had faced a reduction in referrals and a reduction in the number of hospital patients they've been able to transfer to community services. It is particularly difficult to deliver services in prisons as many of our psychiatrists have struggled to access patients although we have had reports that this is improving.

Another area where our psychiatrists have expressed significant concerns is within addiction services. Our Addictions Faculty members have told us that some people with alcohol addictions problem are drinking much more and becoming even more chaotic in their lifestyles as a result of the pandemic. We have had reports of a significant number of people relapsing because of the strains of lock down and being cut off from their friends and families.

How mental health services have adapted to deal with the crisis

Many providers of mental health services reacted quickly to change the way services act in response for the crisis. Many psychiatrists are currently working an 'altered timetable' due to reconfiguration of services.

During the COVID-19 pandemic, it is essential that those who use mental health services continue to get the care they need. Remote consultations, using telephone calls, audio and video to provide care for patients has already become a fundamental part of the way mental health services provide care. As we move beyond the peak of the crisis, this is likely to become more standard practice and there are concerted efforts to continue to increase capacity.

Many psychiatrists are currently working remotely, showing that services are able to provide flexibility for staff as well as patients.

Those with a lack of digital literacy, lacking in confidence using technology or with little or no access to digital platforms must not be disadvantaged. Use of telephone consultations, rather than more complex video platforms may be sufficient for lower risk conversations or to ensure engagement with those who lack digital technology or skills.

The College has published online resources for people with a mental illness and their carers on issues such as medication and how to manage their conditions during the crisis.

Access to PPE

A pair of college surveys found that psychiatrists are being forced to put themselves and their patients at risk, delivering care without adequate PPE or access to tests for themselves, their families or their patients[1].

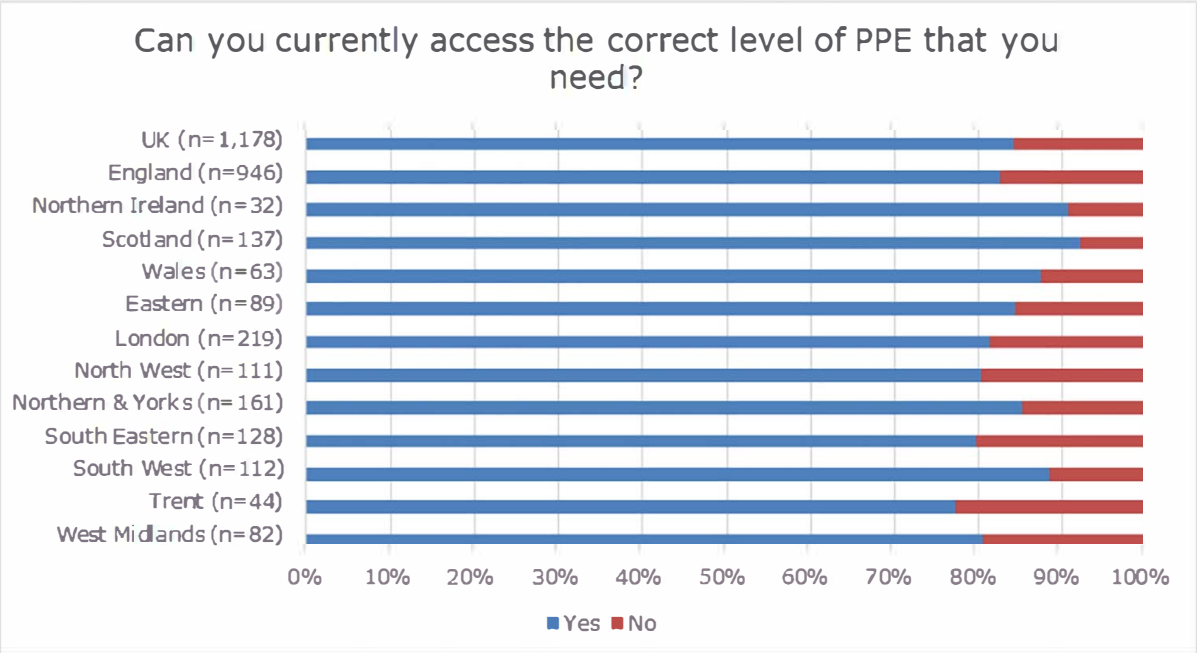
One psychiatrist surveyed said "There are extreme shortages of PPE and most of us are at risk. Only very limited supply is obtained and most of the time frontline staff are refused risking their lives. Staff are terrified and afraid."

Our survey (in the field from 1-6 May) has shown that a significant proportion of psychiatrists are concerned that they are not able to access the level of PPE set out in the guidance.

- Around 16% of psychiatrists in the UK don't have access to correct PPE.
- In Scotland this was 8%, Wales 13%, Northern Ireland 9% and 18% in England.

The national and regional breakdowns are as follows

Chart 1 - Are you able to access the following PPE kit when you need it (in line with the latest guidance from your organisation)? (NB – don't know responses were excluded)



***Update. We further surveyed members in Wales in June and the figure was consistent.**

Some of our psychiatrists have previously expressed concerns about the potential impact the lack of adequate PPE is likely to have. Some of the most concerning responses to our first member survey (in the field from 15-17 April) included psychiatrists saying that:

- *"Last week we did CPR on a patient who had hung themselves with no fit tested PPE."*
- *"There are extreme shortages of PPE and most of us are at risk. Only very limited supply is obtained and most of the time frontline staff are refused risking their lives. Staff are terrified and afraid."*
- *"Spitting in Covid positive patients is a real issue and not able to get the appropriate PPE, social distancing impossible in inpatient settings."*

Access to testing

The other major concern raised by our psychiatrists is that a significant proportion were unable to access tests for themselves, their families or their patients if they have concerns if they have COVID-19. The current Government guidance states that any NHS worker or their family member with suspected COVID-19 should be able to access testing and that tests should be given to any new patient entering an inpatient setting.

When our psychiatrists across the UK were surveyed (1-6 May) we found that, In Wales:

- Around one in ten psychiatrists working in the NHS said they were not able to access a test for COVID-19 for themselves if they had symptoms, if you include those who did not know if they could access a test it was up to almost a quarter.
- One in four either could not or did not know if they could access a test for their patients
- Almost a half (45%) could not or did not know if they could access a test for members of their household

Whilst these findings have improved since our first survey (15-17 April), there are still areas for improvement.

***Update. We further surveyed members in Wales in June, with reported increased access for testing for patients.**

- Less than one in ten psychiatrists working in the NHS said they were now not able to access a test for COVID-19 for themselves if they had symptoms, if you include those who did not know if they could access a test it was still up to almost a quarter.
- The availability for testing for patients had improved, with 93% reporting that they were able to access testing
- Still, almost a half (45%) could not or did not know if they could access a test for members of their household

Infection control and prevention

The majority of mental health units in the UK were never designed to contain a highly contagious illness. Potential environmental risks include aged estates with a significant proportion of dormitory style accommodation, small shared offices, shared computers, shared patient facilities, sitting or dining rooms, shared toilets, poor ventilation and air-conditioning. Particularly worryingly last year there were 1,176 patients (UK-wide) having to share mixed dormitories[2].

In addition, it is often the case that some patients may be unable to follow advice on containment, isolation and testing, which presents a further clear infection risk to be considered and managed.

We are concerned that some NHS mental health estates are unsuitable, making it very hard to follow guidance. The guidance includes recommendations that all new patients coming into a mental health, learning disability, autism, dementia or specialist inpatient facility are tested for COVID-19, including asymptomatic patients, and kept separate from other patients until they get their results back.

As shown above many of our psychiatrists have expressed significant concerns that they are currently unable to access testing for their patients. To date it has been very difficult to effectively cohort due to lack of adequate access to testing, therefore it is important that effective delivery of this change in testing policy in mental health settings is monitored and not overlooked.

Many sites also lack the space to keep patients separate especially those with mixed dormitories. Consideration is needed on how Health Boards can be supported to undertake the complex task of cohorting effectively within their estates, both in the immediate term and looking to the medium and longer term.

On admission, space is needed for confirmed COVID cases, a second space for patients confirmed via testing to be COVID negative and a third space patients whose COVID status is unconfirmed while test results awaited. In addition, patients who need shielding should be kept away from those with confirmed COVID.

It is important to understand the extent to which local areas are able to follow this guidance, and this is monitored, and additional support is offered to those areas that are struggling to follow them.

How we can we support the mental health of NHS staff?

At this time, NHS staff may feel stressed for many reasons such as having to make difficult decisions about patients' care, the amount of work, being uncertain about the future, worrying about taking the virus home with them and infecting others, and/or less contact with family and friends.

The role of NHS team leaders, managers and supervisors is crucial to ensure NHS staff have the mental health support they need. NHS leaders need to have frank discussions with staff about the challenges that lie ahead, not to sugar coat them but also not to overstate the trauma they are likely to face. These discussions should address the difficult decisions that staff may have to make.

We also recommend supervisors speak with their teams using structured forums similar to the ones provided by Schwartz Rounds. Such forums enable staff to come together with their leader after their shift and talk honestly about what did and didn't go right, the difficulties they faced and the associated emotional reactions.

While staff will have limited time to be involved in such discussions, this approach is likely to reduce the potentially damaging mental health impacts of working on a stressful hospital ward. This should be done during staff's normal working hours.

For further information, we have published a range of resources for team leaders and supervisors as part of our COVID-19 guidance. We have also developed specific resources for psychiatrists on taking care of themselves as well as helping other healthcare professionals.

Despite the challenges they face during the pandemic, most NHS workers will not suffer from a mental illness. With good leadership, as well as properly preparing and supporting NHS staff, most will avoid developing longer-term difficulties.

For those who do need help, we should provide evidence-based care both in the short term to help NHS staff get back to work and in the long term. The available evidence strongly suggests that the support given to NHS staff members as the crisis begins to recede is of critical importance in determining whether they will experience psychological growth, develop a mental health disorder or neither.

Supporting the health and wellbeing of NHS workers following the first COVID-19 outbreak is likely to be even more critical. To this end, the NHS must give its staff members - who have been working intensively in arduous circumstances - sufficient time to 'reset' before they embark on their usual work.

This time will be crucial for them to access the social support they need, and to readjust to the 'new normal' without being under too much pressure while trying to recover. Should there be second wave of coronavirus this rest period will be even more crucial

We have developed some concrete elements that we believe should be put in place for staff in every NHS Health Board, including:

- Any staff member who unexpectedly does not turn up for a shift should be proactively contacted.
- Once someone completes their COVID-19 work they should be thanked, be provided with opportunities to informally mix with their colleagues and given relevant mental health and welfare information.
- Workplace supervisors should carry out a structured return to post-COVID-19 work interview.
- Staff should be written to again three and 12 months [and possibly later] post completing their COVID-19 work and be given information about how they can check their own mental health.

How we can we support people's mental health after the initial peak?

It seems inevitable that once the pandemic is past its peak, there will be an increase in demand for mental health services and for support for the general population. That need will increase more if there is an economic downturn. This may be because of pent up demand caused by the current fall in referrals, the consequences of lockdown, economic uncertainty and the trauma of contracting or losing loved ones to COVID-19.

The recent ONS wellbeing survey found that between 20 March and 30 March 2020 almost half of the population of Great Britain (49.6%) reported high levels of anxiety. This compares to 21% of people who said the same last year[3].

A significant economic downturn following the crisis is widely predicted and there is strong evidence of a link between economic difficulties and higher rates of mental health problems and suicide[4]. We have already seen from the recent ONS survey that people who had experienced a reduction in household finances because of COVID-19 reported 16% higher anxiety on average[5].

Mental health services, which are overstretched at the best of times, will come under even more pressure. One of the biggest causes of this is a lack of trained staff.

In March, we released our manifesto for the 2021 Senedd Cymru elections. We highlighted particular areas of focus for developing the workforce in Wales that will support ambition, and it's essential that this is confirmed and commitments are made within the mental health workforce strategies that have been outlined within Welsh Government's 'Together for Mental Health Strategy'.

It is important that these commitments are not forgotten, and that recommendations from our manifesto are brought forward in working towards achieving parity between services; and respective of parity in developing parity for a mental health workforce.

Coronavirus and the impact on people with protected characteristics

Over a third of people with a severe mental health illness (37.6%) also have a long-term physical condition[6] meaning that they are disproportionately at risk of being affected by COVID-19.

In the UK, people from Black, Asian and minority ethnic backgrounds (BAME), face persistent and wide-ranging inequalities. An individual from a Black, Asian or minority ethnic background is more likely to experience poverty, to have poorer educational outcomes, to be unemployed, and to come in contact with the criminal justice system[7]. These, in turn, are risk factors for developing a mental illness.

Emerging data from the COVID-19 pandemic clearly shows that BAME groups are significantly more likely to die from COVID-19[8], the reasons for this are currently not well established, though societal inequalities are likely to play a role.

This submission focuses on what impact the crisis is having on mental health services and those services that are delivered to people with protected characteristics.

We have also looked to address the Coronavirus Act 2020 and the impact that will have on those with protected characteristics.

Recommendations to support people with protected characteristics

- *The emergency changes to the Mental Health Act should only be used where patients would otherwise be put at risk and their use should be closely monitored.*
- *The need for the enactment and prospective enforcement of the MHA emergency changes, should be closely monitored and justified – At present, we do not support a case for enactment and enforcement*
- *Health Boards should adopt the College guidance and work with individual staff to develop appropriate and robust risk mitigation for BAME mental health staff, and access to support should be readily made available and accessible.*
- *When the peak of the crisis is over mental health services should not go back to normal instead commissioners should learn from the National Collaborating Centre for Mental Health Advancing Mental Health Equality (AMHE) guidance when redesigning services*
- *When supporting patients during the COVID-19 crisis staff should use the least restrictive option that is possible*

The emergency coronavirus legislation and mental health

Schedule 8 of the Coronavirus Act creates the ability for changes to be made to mental health legislation across the UK. These changes have so far not been enacted apart from those related to the Mental Health (Northern Ireland) Order 1986 - in Northern Ireland.

The changes to the Mental Health Act 1983 (England and Wales) (MHA) would allow certain functions relating to the detention and treatment of patients to be carried out with fewer doctors' opinions or certifications. It also temporarily allows for the

extension or removal of certain time limits relating to the detention and transfer of patients. Full details of what this would entail can be found on our website[9]

Although Black British adults had the highest mean score for severity of mental health symptoms, they were the least likely to receive treatment for mental illness. Where they do come into contact with services, it is disproportionately based on a detention order requiring them to stay in hospital[10].

If this legislation is enacted, it would disproportionately impact these groups. We are extremely conscious that enacting MHA emergency powers would weaken patient safeguards, so it is essential that their use must always be justified. People shouldn't be denied access to the care they need, and potentially left in a situation where their own life is at risk due to a lack of staff. If those needing care don't get it because of a depleted workforce it will further affect an already disadvantaged group and so on balance.

We have monitored the views of psychiatrists closely in relation to delays that may have been experienced in using the MHA in the last couple of months.

75% of psychiatrists had not reported trouble convening a MHA assessment in Wales, only 7% had (the remaining responders are not convening community MHA assessments during their work)

Presently we do not believe there is an evidence base to justify enforcement of the MHA amendments in Wales, should they be enacted by the UK Government.

Enacting the MHA emergency powers would weaken of patient safeguards. Therefore, their use would need to be justified every single time they are used.

If emergency powers are enacted, they should only be used where necessary and justifiable. It is essential that it is clearly communicated that the powers, if enacted they should not be used nationally, only where the lack of staff caused by the COVID-19 crisis means a patient's safety is being put at risk and where there is no alternative.

We are also very conscious that the MHA is currently applied disproportionately to people from some BAME communities.

RCPsych recognises that racism and racial discrimination is one of many factors which can have a significant, negative impact on a person's life chances and mental health. We are particularly concerned about the disproportionate impact on people from Black, Asian and minority ethnic communities, notably those of Black African and Caribbean heritage. It can lead to substantial disparity in access to and experiences of various areas of psychiatric care, including crisis care, admissions, pathways into care, readmissions, use of seclusion and detentions under MHA. [11]

We have highlighted our cautious position to Welsh Government.

In 2018 the RCPsych paper on racism in mental health[12] highlighted that although Black British adults had the highest mean score for severity of mental health symptoms, they were the least likely to receive treatment for mental illness. We repeat our calls that efforts to tackle this should be urgently prioritised by Government, non-governmental organisations and professional bodies.

Following this paper, the National Collaborating Centre for Mental Health based at the RCPsych published a document called Advancing Mental Health Equality (AMHE)[13] which is a resource to support commissioners and providers to tackle mental health inequalities in their local areas[14]. This document should be a key tool for mental health commissioners to plan how they should reshape their services as they adjust following the COVID-19 crisis, including how any use of remote consultations and other digital solutions are appropriately designed.

Additionally, The College has endorsed the Cultural Competency in Mental Health Services initiative that has been developed by Diverse Cymru, working closely in its development and in ensuring that every health board is working towards this standard.

We also support the recommendations identified with the First Minister's Socio-Economic Group advisory report that amongst many positive recommendations advises:

The Report asks Welsh Government to commit to support and fund practical ongoing actions in providing appropriate, equitable, and culturally competent mental health services to individuals from Black, Asian and Minority Ethnic backgrounds to help address the acknowledged inequities that exist in mental health take-up and service provision. It suggests that this should be achieved through utilising the Royal College of Psychiatrists in Wales endorsed Diverse Cymru Black, Asian and Minority Ethnic Mental Health Cultural Competence Certification Scheme and any other such practical actions.

We welcome Welsh Governments commitment to this recommendation.

Mental health services for older adults

A recent survey of RCPsych members has found that psychiatrists working with older adults have seen the biggest drop off in the ability to deliver regular appointments. With over half saying that long term appointments have either decreased or significantly decreased since the crisis started.

This is not surprising considering they are the group most at risk from infection and have been advised to take extra precautions around isolating. It may also be that they are the group less able to engage with their mental health team online. Although it is important not to generalise and say that all older people will not be comfortable talking to a psychiatrist over the internet.

Our older adult faculty has also reported restrictions on care home admissions. Although, this is for the safety of existing residents our Old Age Faculty is concerned for their patients with advanced dementia that need constant support and care but cannot be admitted to a specialist facility.

Equalities considerations on COVID-19 impact on healthcare staff

In response to emerging evidence on the disproportionate impact of Coronavirus on people from BAME communities, the government has set up a review into this issue. This disproportionate impact is also being seen in the healthcare system, with evidence emerging that disproportionate numbers of BAME healthcare staff are being affected by Coronavirus[15],[16],[17],[18]. In response to this, the President of the Royal College of Psychiatrists set up a Task and Finish Group to look into this issue, and develop recommendations for mental health services across the UK to help them support BAME staff, put risk mitigation processes in place, and develop longer term solutions to address inequality in the workplace.

The Task and Finish Group reviewed the evidence that currently exists on the impact of the virus on BAME healthcare staff, and has found that the disproportionate mortality of health and care staff from black and minority ethnic backgrounds during the COVID-19 pandemic is not fully explained by other suggested risk factors. This has an adverse impact on the entire mental health workforce and additionally involves further direct and indirect harm through longer term morbidity, physical recovery and psychological consequences of this unequal disease burden.

There are multiple risk factors associated with the increased impact of COVID-19 in the BAME health workforce, which include biological, medical, sociological and structural issues[19],[20]. WRES data also indicates that BAME healthcare staff are more likely than their white counterparts to experience bullying and discrimination in the workplace[21], and so therefore may not feel able to freely raise concerns.

This underpins the need to ensure that BAME colleagues are proactively supported by leadership and management during and after this crisis, for their security and the security of the future mental health workforce. In the short term, appropriate and robust risk mitigation for BAME mental health staff should be put in place during the COVID-19, and access to support should be readily made available and accessible.

In the longer term, recommendations on addressing inequalities within the health workforce and system must be implemented in a robust and transparent manner and understanding of the value and strengths of a diverse mental health workforce acknowledged and communicated across the system. Furthermore, the longer-term

psychological impacts of the COVID-19 pandemic on BAME healthcare staff may be significant and complex, and mental health service management should lead the way in ensuring support is adequate, available and accessible for those that need it.

The full report from the group identifies the need for a good, collaborative risk assessment that will enable robust risk mitigation to be implemented and support individual staff members to feel more confident about being protected at work while undertaking duties in the care of others.

We have shared with the Advisory Group that has been convened by Welsh Government and are keen that this recommendation is taken forward.

Reducing restrictive practices

People with a learning disability and/or autism in inpatient settings are already vulnerable to and disproportionately represented in the use of inappropriate and excessive restraint, seclusion and long-term segregation. Restrictive practices are also used disproportionately on those from ethnic minority communities, women and girls. [22]

During the pandemic services and staff are still required to commit to reducing their use of restraint. The only changes to patient care should be those needed to manage and prevent the spread of COVID-19. At every opportunity, they should consider whether there is a less restrictive option available to them. Any use of restraint must be appropriate, be proportionate to the risks involved and end as soon as possible. Providers should refer to their ethics committees where required and as always it is essential that all staff using restraint techniques are fully trained.

RCPsych has developed the COVID-19 Mental Health Improvement Network to support mental health teams to share and learn from each other to maintain and improve safety in response to the COVID-19 pandemic. It is working to identify areas where improvement packages are needed during this period, one of such areas is restrictive practice. A short "change package" is available, along with a series of webinars in order to support services in this area.

Once the initial crisis is over it is critical that learning from RCPsych's reducing restrictive practice programme is considered for wider roll-out across Wales. The initial pilots from England have demonstrated that with the right support health boards can significantly reduce how often they use restrictive practices.

Additional Comment

We have closely monitored the views of psychiatrists, patients and services during this time. It is important to recognise how the mental health workforce, alongside patients and carers have adjusted to the pandemic under significant pressure.

It does further highlight that there is not parity between physical and mental health, and that there is need to strategically invest to support some of the most vulnerable people in society.

It is essential that the College has direct contribution in how services will look to recover and prepare for a second phase. We have had positive discussion with NHS Wales and Welsh Government during this time, and are hopeful that recommendations that we have given are taken forward.

We must all also ensure that planning considers opportunities that can be sustained, post COVID-19 and will continue to have an impact across the health service.

Once such consideration that the College would particularly choose to be highlighted and recognised, is the successful work of Technology Enabled Care Cymru (TEC Cymru). The rollout of telehealth and video consultation was informed from a pilot project 'CWTCH', for CAMHS services in Gwent. The pilot lead, Prof Alka Ahuja was subsequently seconded to Welsh Government as a clinical lead for TEC Cymru.

There are a number of additional innovations that stand to make a significant improvement to services, across the NHS as well as ensuring we work towards a parity between services. These are highlighted in our manifesto and we believe will compliment much of the Committees considerations that will inevitably arise from this inquiry, in considering what the Health & Social Care service could like in recovery and post COVID-19. We would be keen to follow up and give further suggestion to the Committee as services continue to adapt.

As an additional point in this response.

40% of psychiatrists in Wales have reported that their mental health and wellbeing has suffered or significantly suffered during this time. Alongside the challenge presented by the nature of the virus; there is more that can be done to support the impact of a pandemic on mental health services, its patients and workforce. The College is well positioned to advise and reflect on the experiences of psychiatrists.

Our recommendations

- *That specialist mental health services have a direct voice within the recovery planning from Welsh Government*

- *That the impact upon the wellbeing of Psychiatrists (and its unique determinants as highlighted in this response) as well as the wider NHS and Social Care workforce is further examined by Welsh Government in partnership with the College.*

Section 2 – Additional thoughts and recommendations

We have provided some additional context for the Committee based upon further reflections since the initial written evidence submission.

- RCPsych Wales will commit the next 12 months of its academic events and CPD programme to be focussed upon Covid recovery for mental health services. We would wish to do this in partnership with other key stakeholders, including Welsh Government.
- Welsh Government should commit the role of Clinical Lead for TEC Cymru as a permanent role.
- Welsh Government & NHS Wales should work with key stakeholders including RCPsych Wales to consider and implement ways to alleviate waiting lists that have significantly grown during the first phase of the pandemic.

We have written to Welsh Government to offer support in addressing memory assessment waiting lists across health boards in Wales, with consideration for additional consultant clinics, utilising remote assessments to tackle memory clinic backlogs.

Recommendations for the NHS estate

We would wish to reinforce recommendations on the appropriateness of much of the NHS mental health estate. There are both short and long term challenges and opportunities for improvement, and a parity between service investment.

Recommendations for Supporting Psychiatrists

- NHS Wales should work with RCPsych Wales to offer guidance and support to Health Boards to ensure SPA time, Job planning arrangements, Rota arrangements and other considerations, during recovery and during a potential second wave.
- NHS Wales should adopt the RCPsych 'Covid organisational wellbeing' guidance across Health Boards.

- NHS Wales should adopt the RCPsych 'Going for Growth - An outline NHS staff recovery plan post-Covid' guidance across Health Boards.'

Additional information on some vulnerable groups

Children & Young People

We were pleased to give evidence on the 9th June to the Children, Young People & Education committee on the impact of the pandemic, and welcomed the interim report published on the 8th July.

We highlighted several observations alongside colleagues working in mental health.

- Many children will respond to COVID-19 in a healthy way, but there are others with intellectual disability, Autism Spectrum Disorder, children with ACEs and children with SMI who will not have been as able to process this experience in a healthy way
- Children who are transitioning between settings (schools, to universities) should be recognised as being at higher risk of poor mental health
- Ongoing support for parents' mental health needs must be provided in order to support the mental health of children
- Ongoing support to teachers to be confident, manage anxiety and be psychologically minded and open with their pupils must also be provided
- We should all continue to encourage parents and young people to seek help, should they need it, in light of expanded access to services

Learning Disability

The loss of consistent activities and disruption of routines for people with autism, learning disabilities or both has been significant, This has in some cases resulted in an increase in anxiety and/or challenging behaviour and on occasion led to the need to prescribe medication that would not have been necessary had these changes not occurred, such is the impact on some individuals' lives.

Whilst there is an understandable and distinct lack of reversibility to the current restrictions, this is however leading to difficulties in planning sustainable alternatives for people with learning disabilities, in particular regarding respite provision. Many of those who would normally access respite services now have not been able to do so (or not at the frequency of that pre-pandemic) or have chosen not to due to the potential perceived risk. This is resulting in increased carer burden and strain and

potentially increasing the likelihood of placement breakdown and emergency hospital admission (which is compounded by an already lacking provision of respite services and alternative placements).

The changing laws, guidance and regulations relating to the pandemic and restrictions: inpatient advice/guidance has lagged behind in terms of enabling patient leave. Patient leave is an important part of recovery for many patients and also a safety net for transition into a new placement. Restrictions on leave due to risks of covid transmission to other people in the community (in the shared accommodation) or back into hospital has made it very challenging, and likely delayed discharges. There is also a significant impact on people with ASD of the rule changes and stress of worrying about the public not following rules, resulting in increased anxiety

Patients who live in (shared) supported living not being able to form a "bubble" with family members has also proven significantly challenging. Patients may benefit from Skype/FaceTime but for some individuals this has had the opposite effect: causing more distress.

Due to the need to have a single point of access for admission, patients experience an additional transfer from the SPA to the AATU after 2 weeks. It is hard to say the exact impact of this but it seems likely that it will lengthen admissions and could cause some patients to regress on transfer.

Virtual consultations have proven successful in LD psychiatrists can continue to review and see/include patients. In some situations better than seeing a patient face to face with masks on as able to assess mental state to an extent and develop rapport more easily. Also in some cases results in better patient engagement (e.g. patients who don't like going to clinic and carers attend only pre-pandemic). For others though, their involvement may be reduced. Difficulties with technology are a barrier and there can be reluctance of families/carers to engage with technology (often preferring a phone call when given the option).

Earlier on during the pandemic (and could be the case again with local lockdowns) patients who need to continue to access the community for their mental wellbeing were stopped and interrogated by the police. In some cases they were told to return home. This resulted in anxiety for family/carers as well as for individuals with learning disabilities. In some cases patients/family were not keen to access the community again – impacting on their and the individual with learning disability's wellbeing.

There was reduced / cancelled / delayed annual healthchecks with some GPs as they were classed non-essential. Annual healthchecks are an important component of

reducing health inequalities by attempting to identify any emerging health problems early.

- NHS Wales should work with RCPsych Wales to ensure that day services are available and open/re-open when safe and appropriate, and not left closed or unavailable unnecessarily

Older people

We are currently involved in a project with Old Age psychiatric teams in both ABUHB, and BCUHB in delivering memory services through video consultation. This project has been well supported by TEC Cymru and Digital Communities Wales to date, with evaluation arrangements made.

We feel this should be considered by Welsh Government upon evaluation, as it offers increased opportunity to deliver appropriate remote services.

People in forensic care

As previously mentioned, we have been made aware that many medical staff could not see patients in prison because of COVID and there was now a backlog of illness.

Additionally, it has been reported that people were being held on remand for lengthy periods over alleged offences and the associated psychological impact will be significant.

There have been different approaches undertaken in private and public forensic units, both attempting to strike a balance between seeing the patients regularly but not risking the spread of COVID. Visiting in forensic units had been heavily curtailed.

Liaison Psychiatry Services

The impact of Covid on the Liaison Services

a)Alternative pathways to Emergency Departments (ED) have been created by some Health boards (e.g. BCUHB) to reduce risk of Covid exposure to patients and staff. This was well appreciated by the emergency department and general hospital but difficulties and safety issues cannot be overlooked.

Specialty specific alternatives to ED – including alternatives for patients with a clear mental health emergency need and no physical health needs, should be provided to reduce waiting times in ED, improve hospital flow and give service users a better experience.

b)Additional beds e.g. the building of Dragon's Heart Hospital in Cardiff.

These additional beds created great spaces for improved flow away from the general hospital, however lack of natural light and use of artificial lighting did not help older patients with cognitive impairment with their orientation and recovery especially following Delirium.

When building new hospitals, environmental research about Delirium and our psychogeriatric populations should always be taken into consideration.

c)Use of technology- this has been a fast tracked change realised during Covid. E.g. Attend Anywhere has been used for liaison outpatient clinics;
Telephone contact by liaison staff to known frequent attenders has been used in the initial weeks for support.

Modern technology needs to be available across Wales, particularly in rural areas. Some areas still have problems accessing good signal making it difficult for provision of services even remotely.

Impact on Staff

- Liaison services immediately recognised their role in looking after the well-being of colleagues in the general hospital. Some were instrumental in ensuring the provision of a concerted staff well-being response within their Health boards, others participated directly by supporting distressed colleagues and being frontline. Generally there was a sense of team work and readiness to work outside one's own comfort zone.

Organisations need to pull resources from both Physical and Mental Health, as well as Primary and Secondary Care, Health and Social Care, to find solutions to many more problems that we are facing with the Health of our Nation.

For instance, now we are starting to see disabling anxiety and chronic non-specific physical symptoms – like post viral fatigue in some patients post Covid. There is no clear pathway or agreed approach to address these problems within primary or secondary care, physical or mental health.

- Some liaison services experienced more than 50% reduction in staffing levels due to redeployment, shielding, stress related issues and self-isolating. For some services this was on top of already strained services with long term recruitment issues or delays in application processing.

There is currently very minimal flexibility in the system to allow for drops in staffing levels. There has to be an increased awareness and proper measurement of gaps in services and staffing gaps in Welsh health services.

- Liaison services split between the hospital and alternative pathways at times made it difficult to run a safe service. There was an expectation to cover alternative pathways and additional services (such as the Dragon's Heart Hospital) with the same staffing. Even where resources were made available e.g. through Covid funds, the lack of professionals readily available to take up extra work made it very difficult to employ the additional staff.

There are plenty of opportunities for training new staff in Wales but there is no surplus of clinical staff to dedicate time to this. Clinical work always trumps over other activities. There is a need for more training posts within health services to provide a great experience for trainees whilst on work experience. These in turn would want to join the Welsh workforce. This applies to doctors, nurses, allied health professionals etc.

- Trainee doctors and other staff experienced working different shifts and facing Covid deaths on the wards, especially wards for older people. The psychological impact of the relentlessness of this is yet to be discovered.

The long term effects of Covid on staff should be monitored. A database to identify if problems are directly or indirectly Covid or non-Covid related would help.

- PPE fatigue and burnout amongst both clinical and management staff due to the many uncertainties and unpredictability about their day to day shift. E.g. having to cover a 12 hour shift alone because colleagues self-isolating and shift could not be filled. Letting people down and guilt feelings because patients are unable to be seen in a timely way.

Staff should not have to work in such conditions that threaten their own health. There needs to be more resources and these have to be more readily available.

Some services experienced an initial reduction in referrals when lockdown was first announced and hospitals were dealing with reduced plans as well as emergency admissions. This lasted about 2-3 weeks but since, referrals picked up with:

- a new cohort of patients not otherwise known to services, presenting with anxiety, depression and psychotic episodes –possible isolation or effects of unemployment on previously fully functional adults
- very well-known patients with severe mental illness, stable for many years, relapsing due to loss/shut down of community services both within the NHS and third sector.
- New patients presenting with self-harm and actual suicide attempts –related to social isolation both in the young and older adults.
- Increase Alcohol intoxication and withdrawals at all age groups
- Delirium both covid related and non covid
- Covid Encephalopathy
- Carers' strain due to lack of respite and limited resources to support them.

More robust NHS and other third sector community services are needed and are crucial for the prevention of mental illness and well-being of our nation. These services need to be age and gender appropriate, non-stigmatising, easily accessible 24/7 for both rural and city residents across the nation.

We hope that this information Is helpful for the committee, in light of an ever-changing picture. We would be keen to provide additional insight into forecasting need and risk at our evidence session.

- Ends

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[1] The Royal College of Psychiatrists issued a survey to its members working in the National Health Service across the United Kingdom. It was in the field from Wednesday 15 April until the morning of Friday 17 April.

[2] https://www.hsj.co.uk/finance-and-efficiency/exclusive-hundreds-of-patients-kept-in-distressing-dormitory-style-wards/7025290.article

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalandeconomicwellbeingintheuk/may2020

[4] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-poverty

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalandeconomicwellbeingintheuk/may2020

[6] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-physical-health-conditions Raj, D., Stansfeld, S., Weich, S., Stewart, R., McBride, O., Brugha, T., ... & Papp, M. (2016). Chapter 13: Comorbidity

in mental and physical illness. In S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digita

[7] Equality and Human Rights Commission, 2016, *Healing a Divided Britain.*

[8] ONS, Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020,

[9] https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/legal-covid-19-guidance-for-clinicians

[10] NHS Digital (2017) Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics

[11] Royal College of Psychiatry, Racism and Mental Health, 2018 https://www.rcpsych.ac.uk/pdf/PS01_18a.pdf

[12] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_18.pdf?sfvrsn=53b60962_4

[13] https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/advancing-mental-health-equality

[14] https://www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/advancing-mental-health-equality

[15] NHS confederation (2020) The impact of COVID-19 on BME communities and health and care staff. Available from: https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Impact-of-COVID-19-BME_communities-and-staff_FNL.pdf

[16] Health Services Journal (2020) Exclusive: deaths of NHS staff from COVID-19 analysed. Available from: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

[17] Kanani, Nikki. Issar, Prerana. (2020) Note for all BAME colleagues working in the NHS. Available from: https://www.england.nhs.uk/blog/note-for-all-bame-colleagues-working-in-the-nhs/

[18] Chakravorty I, Daga S, Dave S, Chakravorty S, Bhala N, Menon G, Mehta R & Bamrah JS. An online survey of healthcare professionals in the COVID-19 Pandemic in the UK. Sushruta 2020 (Jul) vol13(2): ePub 25.04.2020 (pre-print v1.2*) DOI: 10.38192/13.2.9

[19] Kings Fund (2020) Ethnic Minority Deaths and COVID-19: What are we to do? Available from: https://www.kingsfund.org.uk/blog/2020/04/ethnic-minority-deaths-covid-19

[20] NHS confederation (2020) The impact of COVID-19 on BME communities and health and care staff. Available from: https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Impact-of-COVID-19-BME_communities-and-staff_FNL.pdf

[21] NHS (2019) NHS workforce race equality standard: 2019 data analysis report for NHS trusts. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf