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Evidence from qualitative case studies of mental health services in England

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Background

Our evidence is based on qualitative case studies involving four mental health trusts in England, in which we examined the impact of COVID-19 from the onset of the pandemic in February 2020 to the end of the interviews in December 2021 (see Mannion et al. 2022)¹. The study was part of a programme of research on the 'Efficiency, cost and quality of mental health provision' funded by The Health Foundation². We initially conducted a scoping survey with six senior/executive level officials from national stakeholder organisations. At the case study sites we conducted semi-structured interviews with around 13 senior members of staff, local commissioners, and patient representatives per mental health trust (53 in total).

A major theme of our research was to understand how technology was deployed to deliver mental health services, following the outbreak of COVID-19. Thus, we focus our discussion of findings around **Policy Area 1** (The care of patients and service users) **Commitment 2** (By increasing digital connection and providing more personalised care, we can support people to monitor and better manage their long-term health conditions in their own homes, enabling them to live well and independently for longer). We focus on the following questions/themes:

Was the commitment met overall?

- i) Does data show evidence of achievement against target?
- ii) To what extent has the NHS's COVID-19 response affected progress?

Did the commitment achieve a positive impact for patients and service users:

- i) Have patients and service users benefit(ed) directly/indirectly?
- ii) What was the impact on equity of outcome for different groups?

¹ Mannion, R., Konteh, F.H. and Jacobs, R., 2022. Impact of COVID-19 in mental health trusts. *Journal of Health Services Research & Policy*, p.13558196221116298.

² <https://www.health.org.uk/research-projects/efficiency-cost-and-quality-of-mental-health-care-provision>

- iii) Has there been a meaningful improvement in measurable outcomes?

Does data show evidence of achievement against target?

Evidence from our case studies suggests that during the pandemic, mental health providers were able to rapidly reorganise and adapt service provision by switching to digital and telephone consultations to enable remote service delivery. There has been extensive and unprecedented use of online platforms and digital apps to ensure contact with patients and virtual interaction among staff, where face-to-face meeting was not possible.

Despite the progress being made we found evidence in our case studies to suggest that mental health services are a long way off from being able to deliver high quality personalised care for patients and service users to monitor and better manage their long-term health condition(s). First, we found evidence that telephone communication remained the most common mode of remote consultation among providers. Second, we found evidence of variable levels of technological capabilities, or 'digital maturity', among mental health providers. One of our case study providers was a global digital exemplar (GDE), another a GDE fast follower. The GDE scheme was introduced by the National Health Service in 2017 as a special funding 'basket' to support the further development and use of digital technology among a selected number of NHS providers following a bidding process. A GDE is a pioneer in the use of digital technology in healthcare delivery and a GDE fast follower is a provider who becomes affiliated with a GDE and the two collaborate and share best practice in the digitalisation of health service. We found that unlike the two providers who were beneficiaries of the GDE initiative, the rollout of technology during the pandemic was relatively slow for the two providers who were neither a GDE nor a fast follower. Our findings suggest that mental health trusts lacking digital maturity, will not be able to meet this digital commitment.

To what extent has the NHS's COVID-19 response affected progress?

The COVID-19-response to the pandemic-imposed restrictions on movement and physical interactions meant that mental health providers needed to respond to the needs of service users with agility and creativity by adopting innovative approaches to service provision. Thus, COVID-19 emerged as a catalyst for the rapid deployment of mobile and digital technologies and for fast-tracking the digital transformation in the NHS. From our case studies we found that a major impact of COVID-19 was that it created a positive climate of system-wide collaboration, which was stimulated by a more permissive policy environment, more flexible funding models and lighter touch regulation. Along with additional funding from government, the COVID-19 pandemic led to more flexible contracting arrangements between providers and commissioners, resulting in new local freedoms for providers to reorganise services, reflecting in timely and greater investment in digital technology.

However, many of our informants expressed concerns about the ethical aspect of patient choice, which was compromised by the stringent lockdown restrictions during the peak of COVID-19. There were also concerns that remote consultation was less amenable for some mental health conditions, for example emotionally unstable personality disorders and autism, and that this might have unintended consequences for patient experience and outcomes. The Covid-19 response has therefore had both positive and negative effects on the progress towards implementation of the commitment, acting as an impetus and catalyst for change, but also potentially stifling patient choice.

Have patients and service users benefit(ed) directly / indirectly?

There is evidence from our case studies to suggest that mental health patients and service users, as well as staff, benefited tremendously from the improvement in the use of technology in the wake of COVID-19. From our case studies, a major benefit of the use of technology was the speed with which a health professional could contact and provide service for several patients within a short period without having to travel. Informants agreed that in the absence of face-to-face consultations during the peak of COVID-19, the use of IT facilitated a higher frequency of contacts between professionals and patients than would otherwise have been possible.

It is important to note, however, that not all patients and service users can benefit fully from the use of technology in accessing mental health services. Patients who are technologically literate and have access to technological devices and internet connectivity stand to benefit most while others who are

without these opportunities are disadvantaged. Further, while certain services and service users, for example talking therapies, or increasing access to psychological therapies (IAPT), enjoy the full benefit of digital technology, other people living with particular conditions do not. We found evidence that privacy and confidentiality could be compromised during an online consultation, when a young or vulnerable patient, for example, may have other family members in the background or within earshot during a virtual consultation making it difficult for them to effectively interface with the health professional. On balance therefore, it is likely that service users have benefitted from this digital commitment, although the distribution of this benefit and who is able to take it up, may be heterogeneous.

What was the impact on equity of outcome for different groups?

There is evidence of unintended consequences in the rapid deployment of technology during the COVID-19 pandemic - linked largely to concerns that existing inequalities have been exacerbated. Despite its benefits, informants agreed that the expanded use of information and digital technology has widened digital inequalities, which many described as digital exclusion or digital divide. Digital inequalities were affected by the following factors:

- Issues related to digital literacy and technology skills.
- Motivation - some mental health service users may simply lack the inclination or interest in using technology to access health care services.
- Digital literacy and motivation were also believed to be a function of age, with older service users believed to be more reluctant to engage with digital technology.
- The inappropriateness of digital technology and remote service for certain mental health conditions (as discussed above).
- In addition to service users, the case studies revealed that many health care professionals are also in need of training support to be able to use digital technology in service delivery.

The case study findings suggest that digital inequalities can be mitigated or minimised by addressing the challenges outlined above. At the macro level this requires a focus on systemic factors including the need for optimal and equitable investments in digital infrastructure, ensuring interoperability and providing for and enforcing appropriate digital governance and data protection policies. It may be possible to reduce digital inequalities in healthcare by addressing the range of factors which affect the equitable use of digital technology in service delivery through some of the following measures:

- A fair, or equitable, allocation of funds and investments in technology across health care organisations – with some services needing more investment than others.
- Providers may take advantage of opportunities for support from the private sector/charitable organisations. For example, in our case studies one trust applied for and obtained a grant from Barclays Bank, which they used to further develop their digital technology infrastructure. Three of the providers worked with the voluntary sector, setting up internet cafes at strategic locations, which patients could access remotely and free of cost, supporting needy patients with digital gadgets, and others with the basic skills to use digital technology.
- There is a need to invest in digital solutions which may suit the needs of different patient groups, especially those with highly challenging mental health conditions. This would require a collaboration around the design of digital technology in healthcare. Collaboration should involve all relevant agencies and actors, including NHS England/Improvement, NHS Digital, producers of technologies for mental health, mental health providers and patient groups.
- Policymakers should explore the best ways to expand technology infrastructure (in particular broadband provision) across geographical areas, ensuring that the cost of internet connectivity is affordable for everyone irrespective of socioeconomic status.
- As digital transformation gathers pace, patient choice should constitute an important consideration when designing services to mitigate digital inequalities. This means that there should always be some flexibility in service provision allowing for face-to-face consultation wherever service users and patients prefer this method of healthcare provision.

Has there been (meaningful) improvement in measurable outcomes?

For most services, providers found it difficult to determine how the pandemic and the drive to digital transformation had affected quality because it was not possible to routinely collect measures/indicators to provide an authoritative picture of the impact on quality. Many of our informants suggested, based on anecdotal evidence and the fact that there had been no significant cases of serious incidents, that the quality of mental health care during COVID-19 has not been seriously affected. Others provided a range of views around the impact on quality as follows:

- Inequalities were exacerbated for different patients due to the increased use of virtual versus face-to-face consultations.
- In general, virtual consultation was less effective than face-to-face assessment, with video consultation considered more effective than telephone consultation.

- Lack of access or delayed access to services for some people may have affected their quality of care (having missed timely intervention or urgent care).
- There were ethical concerns around the fact that online/remote service delivery was not ideal for those requiring a private 'safe space'; for example, victims of domestic violence, children experiencing neglect etc.
- Concerns were also raised about patient choice – the fact that some service users would have preferred face-to-face to digital consultation, which the COVID-19 crisis did not always permit.

The answer to this question therefore provides again a mixed picture in terms of the impact of the digital commitment on quality of care and patient experience.

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