Written evidence submitted by Dr Mike Marriot (DEL0007)

RE: INQUIRY - Delivering Core NHS and Care Services during the Pandemic and Beyond

I write this in response to the request that "The Committee would very much welcome stakeholders' initial views and reflections on these areas, including suggestions of key questions we should be considering"; I would not be supposing to submit full written evidence to this enquiry, but believe I can be useful for you in considering key questions.

I am responding having had this call flagged by my colleagues at Nottingham Civic Exchange here at NTU. They asked me to consider this as I have worked in NHS mental healthcare in one form or another since 2002, and although I am now predominantly an academic in practice, my teaching and research interests remain in this field and I have ongoing personal and professional connections with people who continue to work in the field full time.

The key concerns that I have had about NHS mental health services in relation to the COVID-19 situation are regarding the ways in which service provision has changed over the last month, and the reasons that this has happened. From anecdotal accounts of both service users and service providers, there has been a fairly wholesale change in service provision whereby community contacts that would normally have taken place in person have changed to provision by distance, either by phone or video contact; indeed, this often seems to be a best case scenario, in that there are also anecdotal reports (e.g. via service-user forums on Twitter) of services reducing these contacts or cancelling them altogether.

As a clinician, my deepest concern is that if this is the case nationally, we should be working on an assumption that a good proportion of the people who require the support of such services will not be accessing them in a way that has as good a chance of supporting their recovery as they would do normally. When we are dealing with the kind of significant distress that require such support, it is not appropriate to assume that there is a like-for-like comparison of effectiveness in face-to-face contact compared with distanced (telephone or online) provision. The nuance of direct human interaction is often a key and necessary element in the ways that mental health services support their service users. As such, if there has been a significant national reduction in face-to-face contact within secondary and tertiary mental health services, there may be a significant number of people whose care and process of recovery will have been put on hold or deteriorated through the lack of access to such contact, either in terms of initial access to services or ongoing therapeutic care. This possibility will impact on the capacity for service provision for all of these service users, quite apart from any possible increase in demand on services that might be anticipated subsequent to the current crisis.

In this context, I believe that the committee should be working to understand how the mental health service community was supported in making decisions about changes to their provision of service. The definition of "Essential" may not have been well translated into practice on the ground, with the possibility that decisions about services and contacts being essential within mental healthcare may have been overly conservative. For example, without direct guidance from central sources that all face-to-face provision in secondary and tertiary mental health services would be deemed essential to continue wherever possible, it is my belief that local decisions might have had to be made based on more general guidance that was intended for public health consumption, rather than professional decision-making; interpretation of such guidance might have led to a greater reduction in face-to-face contact than was necessary in terms of the risk calculations for public health.

On a broader point, I have been concerned that the recent messaging around NHS response to COVID-19 – such as Mr Hancock's statement on the 22nd April that the "NHS has not at any point been overwhelmed by coronavirus"[1] – fails to reflect the possibility that the NHS might not have been sufficiently fulfilling its core functions over this period (with mental health being one such possible example). If the NHS has only been able to contain its management of coronavirus patients through having run other services on a significantly reduced basis, then it appears to me disingenuous to suggest that it has not been overwhelmed.

In this context, I would suggest that key questions for consideration by this committee include

1. To what extent and in what manner did the Department of Health support, guide, or instruct mental health providers in making decisions about continuation, adaptation, reduction, or cancellation of standard mental health provision in the form of face-to-face contacts?
2. To what extent was any such guidance built on expert advice regarding the likely impact upon recovery rates and therapeutic effectiveness in overcoming mental health difficulties by any change in delivery of face-to-face contacts?
3. Is the DoH monitoring and able to report the extent to which face-to-face contacts have reduced for users of secondary and tertiary mental health services, and also the comparable rate of telephone or online contacts for these service users?
4. If there is evidence that these mental health services have indeed reduced the extent of face-to-face contact in their service provision, does the DoH have an exit strategy to support these services in returning to their core standard modes of provision at the earliest opportunity?

As I am no longer directly employed within NHS mental health services and have just recently ceased in my role as a governor for one such service, I am afraid that I would not be an appropriate candidate for your call for more extensive written submissions of evidence by May 8th, but I do hope that this paper is of benefit in your deliberations around potential lines of questioning.

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