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Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages

Version 1, 25 March 2020

NHS England and NHS Improvement

Contents

Key questions and considerations

This guidance has been produced by the national NHS England and NHS Improvement Mental Health, Learning Disabilities and Autism and Specialised Commissioning COVID-19 Response Cell. It provides information and guidance for providers and their clinical and non-clinical teams who are planning for how best to manage their capacity across inpatient and community services, and should support contingency planning, already underway, for a range of resource-constrained scenarios. It will be updated as required.

It provides guidance and considerations for specialised services as well as CCG commissioned services.

Context for guidance

This guidance is one of a suite of resources that should be consulted in parallel. These resources will cover:

- managing capacity and demand within inpatient and community mental health and learning disability and autism services
- patient and carer/family engagement and communication
- workforce considerations
- legal guidance on applications of the Mental Health Act and COVID-19 Bill.

This guidance is for regional NHS England and NHS Improvement colleagues, commissioners (CCG or specialised commissioning), providers, social workers, local authorities, experts by experience, clinical experts, independent chairs for care and education and treatment reviews and others who may be involved in pathways of care.

Considerations for all services

1. General principles

COVID-19, and the national measures being announced to delay the spread of the epidemic will inevitably have a significant impact on both demand for and capacity to deliver support for people with mental health needs, a learning disability or autism. The impact on people's mental health will endure beyond the epidemic.

These are some of the principles that should inform our response as a mental health/learning disability and autism system:

i. People with mental health needs, a learning disability or autism should receive the same degree of protection and support with managing

COVID-19 as other members of the population. This may mean providing additional support, including making reasonable adjustments.

ii. In preparing for and responding to COVID-19, staff in mental health/ learning disability and autism providers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions will need to balance clinical need (both mental and physical), patient safety and risk. Due to the need for rapid decision-making, providers may choose to use an existing patient panel or an ethics committee to advise on decisions.

iii. When considering plans, providers should consider not just patients' vulnerability to the physical infection but vulnerability stemming from mental health needs, a learning disability or autism too. People will be at risk of mortality through suicide, injury through self-harm and of self-neglect, so changes to services need to have patient safety as the paramount concern.

iv. Partnership working is crucial, and responses will need to be co-produced where possible. To both maximise the use of community assets and to draw on the insight and expertise of partners, response plans will need to be developed alongside patients, families, carers, voluntary community sector (VCS) organisations as well as neighbouring mental health/ learning disability and autism providers. This will include planning within an NHS-led provider collaborative, with social care partners, the criminal justice system, commissioners and education providers for children and young people (CYP).

v. Providers will need to maximise delivery through digital technologies to ensure continuity of care where patients are asked to isolate and in response to reduced staff numbers or mobility. Digital technology can also be used to support continuity of social contact for patients, families and carers.

vi. Providers should bear in mind the longer-term impact of the pandemic and associated impacts on the mental health needs of the population and seek to minimise changes that impact on the capacity and capability of the system longer term.

2. Additional funding for the response to the COVID-19 outbreak

Simon Stevens and Amanda Pritchard wrote to the NHS on 17 March 2020 with a letter entitled **IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19**, which set out more detail on the financial regime under COVID-19.

This confirmed that specific financial guidance on how to estimate, report against, and be reimbursed for additional costs is being issued soon. The Chancellor of the Exchequer said in Parliament that, "Whatever extra resources our NHS needs to cope with coronavirus – it will get". Therefore financial constraints must not and will not stand in the way of taking immediate and necessary action – whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

3. Maximising capacity where needed across services for people with mental health needs, learning disability, or autism

In developing plans to maximise capacity where needed across mental health and learning disability and autism services, it will be necessary to consider:

- ongoing risk stratification and dynamic risk registers – to determine who is most at risk physically and mentally and how to coordinate care accordingly
- flexible approaches to deployment of workforce across different settings, for example:
  - using mental health practitioners from community services to provide additional capacity within crisis teams if required
  - ensuing capacity within liaison psychiatry teams within acute trusts to support discharge and patient flow
  - working with VCS partners to create different workforce solutions
  - using technology to provide remote access to professionals where appropriate
- refresher training and upskilling staff on key aspects of physical healthcare to ensure:
  - appropriate physical health monitoring is undertaken; this could be supported by refresher training: eg on monitoring vital signs and the management of a physically deteriorating patient, or rapid upskilling from neighbouring physical health teams
  - a sufficient pool of staff is available to undertake mandatory blood testing: eg for patients on clozapine, lithium, or ADHD medication, this may include pharmacy staff undertaking phlebotomy training and refreshing knowledge, skills and practice in infection control

- standing down activity that is not directly related to care provision, to free up capacity of staff and enable redeployment if needed, eg:
  - non-essential staff meetings
  - non-essential education and training – for further advice please see corresponding workforce guidance
  - audit activities
  - quality improvement initiatives
  - research and trials where safe to do so
  - reporting on targets and key performance indicators where clinical input is required
  - before stopping activity, providers should risk assess the impact on patient safety, business continuity and impact upon other parts of the health and social care system
  - where activity is stopped, providers should record what is stopped and how; changes should be communicated clearly to patients, families and carers in line with their assessed communication needs
- waiting times may be impacted for routine and non-urgent care, including within mental health and learning disability and autism services; disruption and delay should be minimised where possible and patient and clinical safety prioritised.

It may be helpful for services to use the CREST appointment/bed modelling tool originally developed for use with children and young peoples' mental health services: http://dev.cypmh-model.nhs.uk/.

The CREST tool enables an assessment of the level of resources required to properly manage a flow of patients through a service – whether in a clinic (outpatient) or bed-based (inpatient) setting. The tool is particularly appropriate where a queue for a service is time-sensitive. The Inpatient module of the modelling tool is designed to model numbers of beds required to meet demand. Combining together:

  - numbers of patients requiring beds
  - average length of stay expected
  - maximum waiting time for beds.

- Providing a rapid response to the changing situation is vital. Regional and local colleagues may want to make use of daily situation reports (sitreps) to

manage the fast-moving context and enable a rapid response to changes in demand and capacity.

4. Service planning in inpatient settings

Discharge planning to free up inpatient capacity

- Providers should review all current inpatients to support safe discharge where feasible. This will need to be done on a case by case assessment of patients' needs and risks, in partnership with them and their family, carers, and onward care provider (including housing and community teams) where relevant. Discharge plans need to reflect the risks in relation to COVID-19 for individuals.
- This will require close partnership working with adult and children's social care to quickly agree who will fund and arrange the required packages of social support and care for people to be discharged. This may be supported by more frequent meetings of funding panels such as Section 117 panels, regular commissioner/provider calls, temporary pooling of budgets or 'placement without prejudice' arrangements, rapidly working with housing and VCS partners, and bolstering capacity within intensive home treatment teams.
- Cross-system approaches such as multi-agency discharge events (MADE events) could be used.
- People with a learning disability and autism who are inpatients within mental health, learning disability or autism specific services fall under the transforming care work that aims to reduce unnecessary admissions and lengthy stays, and increase the quality of inpatient provision. It is important that key transforming care activity is maintained including community care (education) and treatment reviews (C(E)TR) as outlined in Section 15.
- As providers seek to safely discharge as many patients as possible, those with beds on acute trust campuses should also consider how those will be configured in the context of increasing pressures on critical care.

5. Assessing referrals for admission

- Alongside timely discharge, providers will want to review their processes for assessment of referrals for admission. Referrals can be assessed using care programme approach (CPA) or C(E)TR multi-agency framework before admission with robust review of community alternatives, including

those within the VCS. C(E)TRs can take place remotely using digital technology as outlined in Section 15.

- Dynamic risk registers for people with a learning disability and autism should be in place in every locality and can be used to plan the right support in the community.
- Providers will want to screen admissions for COVID-19 symptoms to ensure appropriate bed allocation.

6. Cohorting physically vulnerable patients

- Providers should consider whether it is possible to reconfigure the inpatient estate to create ‘cohorted’ wards to reduce the risk of contagion among specific, vulnerable groups.
- These include but are not limited to older adults with frailty, patients with a BMI of 40 and over, pregnant women, patients with an eating disorder, and patients with physical co-morbidities as outlined in Public Health England’s guidance on vulnerable groups.
- Providers will also want to consider enhanced physical monitoring and measures to support infection control, such as no visitors allowed, on these cohorted wards.
- Providers will also want to consider whether wards are able to provide flexibility in the management of acuity – for example, by bringing high dependency unit capacity onto a ward if required to prevent vulnerable patients being transferred between wards.
- Providers may similarly want to consider whether usual restrictions on ward types can be relaxed: for example, where ward type is based on age, sex or diagnostic group on a case-by-case basis. A record of decision-making and ethical considerations should be kept.
- Providers will want to consider where enhanced mental healthcare may be needed to mitigate the impacts of isolation, and the use of digital technology to retain social connections.

7. Flexible use of the estate and collaboration with the independent sector

- To follow the PHE guidance on self-isolation, patients with the virus will require single-room accommodation and access to their own bathroom. This will require a flexible approach to accommodation and reconfiguration of the estate, potentially across a group of providers, including the independent sector, in a provider collaborative or local geographical footprint.
- Providers should consider:
  - how additional, single-room accommodation for patients with the COVID-19 virus could be provided in partnership with the independent sector (which may offer a higher proportion of single-room accommodation)
  - whether modifying any available capacity within the adult secure estate is possible, to accommodate voluntary patients.
- Therefore we expect providers to:
  - analyse and map the current inpatient estate
  - identify key gaps, risks and pressures
  - develop a number of contingency plans to match likely scenarios, in partnership with other inpatient providers locally.

8. Implications for out-of-area placements for adult acute mental health services specifically

- The ambition to eliminate out-of-area placements by March 2021 has not changed. However, it is understood that service capacity is likely to be impacted by the outbreak and, in some cases, this may result in the need for out-of-area placements: for instance, through use of additional independent sector capacity.
- Efforts to care for all people locally should continue. However, the advice remains that patient safety is paramount and that when an acutely unwell person requires inpatient admission, it is safer to admit the person to an out-of-area (including independent sector) bed until they can be cared for locally, than to turn the person away and not admit them at all. Patients should continue to operate the continuity principles as far as possible (see Annex B for the principles).

9. Creating additional inpatient capacity

- Providers should consider at this stage whether any beds previously scheduled for closure – e.g. as part of reconfiguration and repatriation

through provider collaborative approaches – could be retained, or what opportunities there are to reactivate mothballed wards.

10. Service planning within community settings, including IAPT services

- Patients with serious mental illness and those with a learning disability and/or autism will require significant support to manage their mental and physical health during this time and support to understand and implement guidance. More detail on approaches to communications and care planning are set out in the supporting guidance on patient engagement and in a new IAPT guide for using digital modes of intervention delivery during COVID-19 (both documents to be circulated shortly).
- In the context of resource constraints, it will be important to maintain up-to-date risk stratifications to prioritise service delivery. In learning disability and autism services, use of the dynamic support register, risk of admission register and regular review between local agencies will be vital to prioritise resources.
- CMHTs/CYPMHS and community learning disability teams may want to move to daily huddles to prioritise who is most at risk of becoming mentally unwell and then use team resources to prioritise contact, in partnership with the VCS where appropriate.
- The options below could be considered to release and create capacity for priority support services in the community:
  - the potential to temporarily pool services which are currently stand-alone, e.g.:
    - pooling resources across EIP teams with CMHT/CYPMH teams to increase capacity or
    - pooling resources across intensive support-enhanced and community learning disability teams
  - releasing appropriately skilled staff from corporate functions to enhance clinical capacity
  - partnership working with the voluntary and community sector to support NHS service delivery.
- We know that providers are preparing now to be able to provide as much continuity of care as possible and avoid partial or complete closures. For example, it should not be the case that services such as IAPT simply close to new patients. The role of IAPT services will be critical in managing the mental health impacts of the COVID-19 outbreak and in supporting those with anxiety and depression and in particular people with health anxiety,

obsessive compulsive disorder, and autism. IAPT services can consider the digital options available to continue to deliver care and more information will be available through updates to this document and IAPT sector specific communications.

11. Partnership working with the VCS to deliver support in the community

- Partnership working with local community groups, the VCS and other providers will be critical to maintaining a viable support service for patients and their families in the community. Providers will want to identify local VCS organisations, what service offers they have and what options there are for working together – either alongside VCS to augment stretched NHS services or as direct replacements for NHS staff.
- Services that a VCS partner may be well placed to provide, which would help to maintain safety in the community, include: peer support, family/carer support, befriending, telephone or social media outreach. In addition, they may work as part of crisis teams to provide telephone support and listening support.

12. Maximising use of digital technologies

- Providers will need to maximise the use of digital and virtual channels to manage the impact of self-isolation on staff and patients. For example, where it is not possible to carry out home visits (eg because a patient may be self-isolating due to symptoms of COVID-19), care contacts may need to take place on the phone or through video consultation. As far as possible, clinical teams should seek to discuss with patients and families/carers in advance about suitability and willingness to engage via different means of contact.
- Providers may consider stratifying patients where there is highest risk of losing contact with them and agreeing how contact will be retained.
- Where parents and carers live at a significant distance or are themselves in isolation, it may be appropriate to offer access to ‘virtual ward rounds’.
- Overall:
  - The use of messaging and video conferencing (with appropriate information governance (IG) is to be encouraged in the context of social distancing.
  - New NHSX guidance to support their use is available. As well as tools such as Skype, WhatsApp and Facetime, there are products designed

specifically for health and mental health. Providers should weigh up the benefits and risks when choosing which of these approaches to use

  - The information Commissioner's office has published a statement and Q&As to complement a joint statement from the health regulators. Further questions can be directed to the NHSX IG Policy team

13. Additional considerations for community-based teams

- Providers must enhance their single point of access (SPA) lines so they are available 24/7. The SPA lines must have capacity to respond to growing demand and support primary care and community services. SPA will need to work closely with social care and VCS in providing a response. Some providers are already augmenting SPA lines using IAPT and VCS staff and may need to introduce additional funding to bolster the service.
- Providers must urgently review information on their websites to ensure it is clear and does not direct people to unnecessarily call NHS 111 (eg unless areas have built dialling 111 into their 24/7 response).
- Areas should avoid disputes about who has ultimate responsibility for payment of a patient's treatment: eg responsibility for a looked after child.
- Given the pressures on primary care, community mental health and community learning disability teams will need to consider how to continue to deliver critical aspects of care: eg blood tests for patients on clozapine, lithium or ADHD medication.
- Where patients are self-isolating, or unable to attend clinics for testing, alternative arrangements will need to be made to ensure people access their usual medications and monitoring. This may include home visits to undertake mandatory testing to keep patients safe.

Considerations specific to services for people with a learning disability and/or autism

14. Identifying those likely to be affected and multi-agency planning for people with a learning disability or autism

- Local areas should have dynamic support processes and 'at risk of admission' registers that help to identify those children, young people and adults with specific support needs.
- It is vital that local areas review these processes and ensure they are including all individuals with a learning disability, autism or both who may be impacted by COVID-19.

- It is particularly important that local areas identify children, young people and adults for whom they are responsible who may be placed outside their local area either in a residential special school or college, social care children placement or adult placement.

15. Care (education) and treatment review

Continuation of C(E)TRs during this period

- Care (education) and treatment reviews (C(E)TRs) are an embedded and essential part of the pathway of care for people with a learning disability, autism or both in inpatient CCG-commissioned or NHS England and NHS Improvement (specialised commissioning) commissioned mental health or learning disability and autism provisions.
- C(E)TRs have an important contribution to make in (i) ensuring people are not in settings or conditions that expose them to increased risk, (ii) facilitating discharge and (iii) in regulating admission in light of pressures on services and workforce.
- While recognising the current COVID-19 guidance means we may need to adapt the way C(E)TRs are undertaken, we expect all local areas to continue to ensure that a process remains that fulfils this role.

"We must maintain the intention, purpose and ethos of the care (education) and treatment review whilst undertaking these in an adjusted way during this period." Dr Roger Banks, National Clinical Director
Learning Disability and Autism Programme

16. Adapting where necessary during this period

- During this difficult period, when everyone understands the pressures on the system and the interim changes that may need to be made in provision, ensuring there is some continued quality assurance is vital for this particularly vulnerable group of individuals.
- There remains a responsibility on the commissioner to ensure a review of care, education and treatment happens and, in particular, the risks to individuals subject to restrictive interventions. We also need to ensure that risks to the individual as a consequence of the COVID-19 pandemic are being adequately addressed and minimised.
- We recognise the significant challenge this may have for providers and commissioners and would suggest that the following adjustments to the process should be made during this period.

17. Community C(E)TRs

- See also Section 10 above for general guidance on service planning for community services.
- It is essential that a process remains for clear review and scrutiny before any inpatient admission, not only considering alternatives to admission but defining clearly the managed risks, purpose, expected interventions, outcomes and timescales of admission.
- Commissioners should make use of technology to enable virtual C(E)TRs to take place with the input of usual participants, to explore all options available to consider if care and treatment can be provided in the community. The use of Skype, WebEx, Microsoft Teams or other technology alternatives should be considered to enable the participation of members including the family.
- This may mean the process is somewhat abridged, but it remains an essential activity and care should be taken to ensure the essential elements of the C(E)TRs are addressed in the time available.
- In exceptional circumstances, the use of the local area emergency protocol or a joint CPA and C(E)TR could be considered.
- Particular efforts should be made to ensure that family members, experts by experience and clinical experts are enabled to join the meetings through technological means.

18. Inpatient C(E)TRs

- See also Section 4 above for general guidance on service planning in relation to inpatient admissions.
- All commissioners should ensure there continues to be a process to review an individual's care, education and treatment during their inpatient stay.
- During this period, however, we recognise that face-to-face full-day panel meetings are unlikely to be feasible and again recommend the use of technology to enable virtual meetings to take place with key stakeholders to review the care, education and treatment of individuals and ensure their wellbeing.
- Particular efforts should be made to ensure that family members, experts by experience and clinical experts are enabled to join the meetings through technological means.

19. Key lines of enquiry for community and inpatient C(E)TRs

- Based on the findings from a recent C(E)TR pilot on new approaches to key lines of enquiry (KLOEs), the key elements that should always be considered even for adapted C(E)TRs are the following questions:
  - Am I safe?
  - Am I in the right place for my care (education) and treatment?
  - Are my plans for my future going well?
  - Is everything supporting me to have the best life I can have now, and in the future?
  - **An additional specific question should now be included in C(E)TR processes that considers the individual's risk of COVID-19 and what is in place to support and protect them.**

20. Independently chaired care (education) and treatment reviews

The same principles noted for C(E)TRs above apply for the independently chaired care (education) and treatment review process.

21. Commissioner oversight visits (6 to 8-week visits) for people with a learning disability and/or autism

Commissioner oversight visits during this period

- During this particularly challenging time, we accept that the six to eight-week commissioner oversight visits may need to be halted to prevent the potential spread of COVID-19. However, the principle of assuring commissioners that the patients they are responsible for are safe and their wellbeing is safeguarded remains the same.

22. Assurance planning where visits are halted/adjusted

- All commissioners should develop a process that enables them to be assured of this using telephone and/or virtual methods of communication with individuals they are responsible for. For this period, it may be important to instigate more regular virtual contact with individuals where this is possible.

23. Host commissioner model (learning disability and autism)

- Host commissioners should continue to maintain their responsibilities for keeping an oversight of concerns in relation to the provision in their areas.
- The COVID-19 outbreak creates additional pressures in the system and on the workforce, and social distancing and self-isolation mean that many of the individuals we are concerned with are potentially more vulnerable than usual, so the additional safeguards and assurance this model provides are essential.

24. Adjustments and assurance planning during this period

- We do not expect host commissioners to visit provider settings during this period, but we do expect them to continue to oversee and accept any concerns raised with them and to follow the agreed process for raising this with the region and if necessary, through the agreed safeguarding processes.

25. Safeguarding issues in inpatient settings

- Safeguarding individuals remains a priority and if safeguarding concerns or issues are raised, we would expect these to be prioritised and managed in the same way as usual. We will not hesitate to make visits if necessary in these circumstances, working closely with families and CQC. There are specific additional vulnerabilities and risks that individuals who are inpatients may experience during this unprecedented period.
- If there is a need to visit, those involved would follow the recommended process for ensuring this remains as safe as possible to prevent transmission.
- NHS England and NHS Improvement and CQC are working together to determine what a joint exceptional response may look like, and we will share further information as soon as this is available.

26. Learning Disability Mortality Review (LeDeR)

- LeDeR remains a very important element of our work and CCGs are encouraged to continue to complete LeDeR reviews, especially where family members have already been engaged in the process.
- However, many of the people who carry out LeDeR reviews have a clinical background and may be redeployed to support activities relating to COVID-19 in the coming days and weeks or may be challenged in continuing reviews due to the restrictions now in place.

- There is recognition that, within the current COVID-19 situation, local systems may not be able to support the completion of LeDeR reviews at this time.
- Local areas should consider how they communicate any pause in their LeDeR reviews with family members in a way that reflects that this is due to this unprecedented challenge in the system, rather than a lack of importance of this review process.

27. TCP/STP footprint areas confirmation of planning to regional leads

As this work is considered an essential continued activity, we are asking transforming care partnership (TCP) areas (or STP footprints, where TCPs have become incorporated into an STP) to provide regional leads with a brief update about how they are going to ensure the guidance above is followed during this period.

We ask that each area answer the list of questions in Annex C and return the completed template to their respective regional lead (see Section 33) as soon as possible.

Thank you for all your hard work during a period of such significant uncertainty.

Considerations specific to specialised services

Much of what is included in this guidance is applicable to specialised mental health, learning disability and autism services too. Across all specialised services the following should be considered:

28. Demand and capacity

- It is important regionally and nationally that we understand and have oversight of the capacity across specialised services so that access to services for the acutely unwell can be managed.
- To facilitate this, it is important that the CAMHS inpatient and mother and baby unit bed availability systems are maintained accurately.
- We are developing similar systems rapidly for all specialised commissioned mental health, learning disability and autism inpatient services and will keep providers updated.
- Closure of specialised commissioned inpatient services purely on the grounds of precautionary measures, in the absence of other factors, is not supported. It is really important that all attempts should be made to ensure

these services remain operational and open to admissions wherever possible.

- If providers are considering temporary closures or restricting admissions for any reason, this should be planned and agreed jointly with the relevant regional specialised commissioning team at the earliest opportunity. This will help ensure any temporary closures can be proactively managed and available bed capacity regionally and nationally can be closely monitored and communicated to the wider system.

29. Access to services

- Robust access assessment arrangements are important to ensure the most acutely unwell patients receive the care they require in a timely way. Specialised services should consider alternative ways in which they can carry out assessments and any subsequent clinical discussions to inform decisions about admission, through digital consultations. Providers need to ensure they have access to appropriate technology to facilitate this.
- Where applicable, it is important to discharge as many patients as possible where it is safe and clinically appropriate to do so. Enhanced focus on delayed discharges at this time will support throughput.
- Ringfencing local beds is not supported in specialised services ordinarily but especially not at this time.

30. Working together across the system

- NHS-led provider collaboratives, those about to go live and those in development, plus other networks and partnerships, should plan across relevant geographical footprints for these patients, acknowledging that these may be larger footprints than for generic mental health, learning disability and autism services.
- The independent sector is already a key provider of specialised services and partner across many of the local arrangements described. Where these partnerships can be further developed with greater joint working, this should happen as soon as possible to ensure best use of all available capacity.
- Specialised inpatient services should consider redeployment of specialist community staff who have the skills to work in these inpatient settings and consider redeployment of other staff who may need a bespoke/rapid induction package – considering training specific to service area, eg security and key training for secure services.

- Estate and capacity should be considered flexibly while taking into account the requirements of specific provision, eg mother and baby units, CAMHS and adult secure services, including physical security requirements.
- Ordinarily for many of the specialised services there are specific stakeholders involved in ensuring the pathways work effectively: eg criminal justice system, Ministry of Justice, Her Majesty's Prison and Probation Service, local authorities, maternity services. At this time, these collaborative relationships are more important than ever to ensure demand is managed and capacity is maximised.

31. Cohorting patients in specialised services

- Cohorting patients in specialised services needs to consider the specialist nature of service provision and the needs of each patient group.
- A proportion of patients within specialised services is particularly physically vulnerable and should be considered in capacity planning: eg pregnant women, those with low body weight or underlying physical health conditions and the elderly.
- For example, adult secure services will need to draw up detailed plans and consider how best to cohort patients while maintaining security and safety of patients, staff and the public. This may involve identifying at the outset a specific ward where patients with confirmed illness may be isolated and another area for those suspected to have the illness, as well as easy and timely access to adequate PPE. Please refer to corresponding workforce guidance for more information.

Other support and information

32. COVID-19 guidance

The latest official information and guidance on COVID-19 can be found here:

Advice for clinicians	https://www.england.nhs.uk/coronavirus/
Advice for the public	https://www.nhs.uk/conditions/coronavirus-covid-19/ https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response
Advice for non-clinical settings: eg prisons	https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance
Advice for NHS England and Improvement staff	https://nhsengland.sharepoint.com/sites/thehub

33. Who to contact should you have additional queries

We always recommend in the first instance that colleagues raise concerns with their regional lead.

NHS England and NHS Improvement regional contact details for learning disability and autism

Region	Contact Details
NE & Yorkshire and North West	Claire Swithenbank (claire.swithenbank@nhs.net)
Midlands	Robert Ferris-Rogers (r.ferris-rogers@nhs.net)
East of England	Karen Lockett (karen.lockett@nhs.net)
London	Heidi Peakman (h.peakman@nhs.net)
South East	Susan Storrar (susan.storrar1@nhs.net)
South West	Kevin Elliott (kevin.elliott@nhs.net)

If you have any queries specifically for the national team, please direct these to england.improvinghealthquality@nhs.net and include '*Learning disability and autism COVID-19 query'* in the subject title.

NHS England and NHS improvement regional contact details for mental health

Region	Contact Details
NE & Yorkshire and North West	Fleur Carney (fleur.carney1@nhs.net)
Midlands	Giles Tinsley (giles.tinsley@nhs.net)
East of England	Helen Hardy (helen.hardy9@nhs.net) Emma Willey (emma.willey@nhs.net)
London	Emma Christie (emma.christie2@nhs.net)

South East	Kevin Mullins (kevin.mullins@nhs.net) Oral Arrindell (oralarrindell@nhs.net)
South West	Ann Tweedale (ann.tweedale@nhs.net)

If you have any queries specifically for the national team, please direct these to england.mhldaincidentresponse@nhs.net and include '*Mental health COVID-19 query'* in the subject title.

NHS England and NHS Improvement regional contact details for specialised commissioning

Region	Contact Details
NE & Yorkshire and North West	Alison Cannon (alison.cannon1@nhs.net)
Midlands	Karon Glynn (kglynn@nhs.net)
East of England	Denise Clarke (deniseclark1@nhs.net)
London	Vimbai Egaru (Vimbai.egaru@nhs.net)
South East	Vanessa Fowler (vanessa.fowler@nhs.net)
South West	Nikki Churchley (nikki.churchley@nhs.net)
National team	Sarah Warmington (s.warmington@nhs.net) Louise Doughty (louisedoughty@nhs.net) Louise Davies (louise.davies10@nhs.net) Marlon Brown (marlonbrown@nhs.net)

If you have any queries specifically for the national team, please direct these to the individuals listed under national team above and include '*Specialised commissioning COVID-19 query'* in the subject title.

Annex A: Resources that have been developed to support clinical practice in mental health settings in light of COVID-19

- The Royal College of Psychiatrists has produced Guidance for psychiatrists and other professionals working in mental health settings (COVID-19)
- The Royal College of Nursing has produced COVID-19 guidance providing general principles for to support the delivery of care

Annex B: Continuity principles for reporting out-of-area placements in mental health acute adult beds specifically

Principles of continuity
1. Clear shared pathway protocols between units/organisations – particularly around admission and discharge
2. An expectation that a person's care co-ordinator: • visits as regularly as they would if the patient was in their most local unit • retains their critical role in supporting discharge/transition
3. Robust information-sharing, including the ability to: • identify cross-system capacity • access full clinical records with appropriate information governance where necessary
4. Support for people to retain regular contact with their families, carers and support networks: e.g. this might be achieved with optional use of technology, transport provision, etc

Annex C: Confirmation of learning disability and autism TCP/STP planning activity in respect of COVID-19

TCP:	[Insert TCP here]	
No.	**Question**	**Answer**
1	How are you assured your dynamic support/ at risk of admission registers have included all of those who may require additional planning and support during this period?	
2	Have you ensured you have included all of those who may be cared for outside your geographical area?	
3	Have you confirmed there are technology options in place to undertake community C(E)TRs? What are they?	
4	Have you planned arrangements with providers to enable virtual inpatient C(E)TRs to continue?	
5	Have you confirmed to family members of inpatients the respective visiting/contact arrangements during this period?	
6	Have you a mechanism for communicating between provider and commissioner any immediate non-admissions/immediate stops to provider units (in the event that staff/patients display COVID-19 symptoms or test positive)?	
7	What arrangements are you making to manage assurance as an interim measure while 6 to 8-week commissioner oversight visits may not be undertaken?	
8	Are you assured that host commissioners in your TCP footprint are clear about their responsibilities during this period?	
9	Have you got agreed arrangements to manage concerns or complaints from family members during this period? If so, what are they?	
10	Have you got plans in relation to LeDeR reviews?	
11	What support do you need from regional or national colleagues during this period?	

Completed by…………………………………………….

Date………………………………………………….