Mental Health Crisis and Acute Care: NHS England’s national programme

*Improving Mental Health Crisis Care, Maintaining Momentum, Hallam Conference Centre 22 June 2016*

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1. What do the recent landmark publications say about crisis and acute mental health care? (including headlines from the Spending Review)

2. Looking ahead – what was the outcome of the spending review and our headline ambitions for the next five years?

3. What work is already underway at NHS England on crisis and acute care, and what are we planning in the coming years?

4. What are the opportunities and challenges ahead for delivering our ambitions?

5. Questions and discussion
CQC thematic review:

✓ Some excellent examples of innovation and practice;

✓ Concordat means every single area now has multi-agency commitment and a plan of action.

However CQC found that.....

- variation ‘unacceptable’ - only 14% of people felt they were provided with the right response when in crisis – a particularly stark finding;
- More than 50% of areas unable to offer 24/7 support – MH crises mostly occur at between 11pm-7am - parity?
- Crisis resolution and home treatment teams not resourced to meet core service expectations;
- Only 36% of people with urgent mental health needs had a good experience in A&E - ‘unacceptably low’;
- Overstretched/insufficient community MH teams;
- Bed occupancy around 95% (85% is the recommended maximum) – 1/5th people admitted over 20km away;
- People waiting too long or turned away from health-based places of safety
Crisp Commission – what did it say? Some of the top recommendations

- **End the practice of sending acutely ill patients long distances** for treatment by October 2017

- **Strengthening CR/HTs**, with a particular focus on ensuring that home treatment teams are adequately resourced to provide a safe and effective alternative to acute inpatient care where this is appropriate

- Mental Health Trusts will need to undertake a systematic **capacity assessment and improvement programme**

- A single set of **measurable quality standards** needs to be created spanning the acute care pathway, including a **maximum four-hour wait** for admission to an acute psychiatric ward for adults or acceptance for home-based treatment following assessment

- Ensure there is an **adequate supply of housing** to enable patients to be discharged from hospital when medically fit.
Mental Health Task Force – crisis and acute recommendations (1/2)

Recommendation 17:
• By 2020/21 24/7 community crisis response across all areas that are adequately resourced to offer intensive home treatment, backed by investment in CRHTTs.
• Equivalent model to be developed for CYP

Recommendation 18:
• By 2020/21, no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards
• At least 50 per cent of acute hospitals are meeting the ‘core 24’ service standard as a minimum by 2020/21.
Mental Health Task Force – Crisis and Acute Care recommendations (continued, 2/2)

Recommendation 22:

• Introduce standards for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible.

• Eliminate the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures by no later than 2020/21.

Recommendation 13:

• Introduce a range of access and quality standards across mental health. This includes:
  - 2016 - crisis care (under development)
  - 2016/17 – acute mental health care (yet to start)
“By 2020, there should be 24-hour access to mental health crisis care, 7 days a week, 365 days a year – a ‘7 Day NHS for people’s mental health’.”

- **over £400m for crisis resolution and home treatment teams** (CRHTTs) to deliver 24/7 treatment in communities and homes as a safe and effective alternative to hospitals (over 4 years from 2017/18);

- **£247m for liaison mental health services** in every hospital emergency department (over 4 years from 2017/18);

- **£15m capital funding for Health Based Places of Safety** in 2016-18 (non-recurrent)
## Our approach: evidence driven, collaborative and systematic

### Process of collaborative working with multi-stakeholder expert reference group

1. Develop evidence based treatment pathway

2. Develop clinically informed access and quality standards (including clock start / stop, interventions and outcome metrics)

3. Develop dataset change specification and commission changes to relevant NHS datasets

4. Conduct baseline audit, gap analysis, opportunities analysis and change modelling.

5. Develop and publish implementation guidance

6. Establish quality assessment and improvement / accreditation scheme

7. Support the development of regional preparedness / improvement networks

8. Ensure alignment of effective lever and incentive systems across ALBs

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**Joint working with HSCIC, HEE and NHSI critical throughout**
Programme scope

**Crisis Care – urgent crisis response - (underway, phase 1)**

- Primary care response (in and OOH)
- 111 (and the DoS) and 999
- 24/7 MH crisis line (tele-triage & tele-health) and 24/7 community-based crisis response
- ‘Blue light’ response, transport hub, S135/136 response & health based places of safety
- Urgent and emergency mental health liaison in acute hospitals (A&E and wards) (+alcohol care teams)

**Acute Care - (yet to begin, phase 2):**

- Alternatives to admission – crisis & respite houses, family placements
- 24/7 intensive home treatment as alternative to admission
- Acute day care
- Acute inpatient services
- PICU services
- *Acute system management, out of area placements, DToCs*

Outside the scope of UEC payment model(s), likely to be considered in context of new MH payment models.

Must ensure that we take a joined up approach for people with co-existing MH and substance misuse conditions...
What have been working on this year?

**Data Data Data!!!**

- Bed types
- Bed providers
- Bed locations
- Bed occupancy
- OATS
- Delayed transfers of care
- Decision to admit
- Decision to home treat
- Waiting times
- MHA use
- NICE recommended interventions
- Outcomes
- Workforce
- Spend

All of this would help us to understand what’s happening in crisis & acute care but we know that we need to expand the ‘data net’ further to understand **acute system** pressures
Dataset development: example from Southend CCG – can we understand nationally, the preventable causes of mental health crisis?

Underlying Themes

- Criminal Justice
- Mental Health Crisis
- Psychological issues
- Multiple Services
- Substance Misuse
- Accommodation
- Learning Disability
- Vulnerability & Safeguarding
- Domestic Abuse
- Alcohol Intoxication

CRISIS
Other 2015/16 progress – embedding mental health crisis in the UEC Review programme

• £30m pump prime investment in liaison mental health

• Strong focus on Mental Health in UEC Review and Vanguards programme

• Winter preparedness programme: mental health crisis indicators for assurance of System Resilience Groups

  1. Link up with Crisis Care Concordat and representation from MH providers in UEC Networks
  2. 24/7 MH Liaison in acute hospitals
  3. 24/7 CRHTTs with fidelity to UCL model
  4. Adequate provision of health based places of safety to reduce use of police cells
  5. Complete and up to date Directories of Service for Mental Health

Transforming urgent and emergency care services in England
Safer, faster, better: good practice in delivering urgent and emergency care
A guide for local health and social care communities
What next in 2016-18?

National focus in 2016/17 on ‘preparatory’ national work before new money comes in – the national levers and incentives to support local delivery:

Develop 5x evidence based treatment pathway projects for crisis and acute care:
- 24/7 UEC mental health liaison in acute hospitals
- 24/7 ‘blue light’ UEC mental health response
- 24/7 community UEC mental health response
- 24/7 UEC response for children and young people
- Acute mental health care pathway

For each of the above, expert reference groups to:
- Referral to treatment pathway, including response times and NICE quality standards
- Implementation guidance
- England-wide quality assessment and improvement scheme
- England-wide baseline audit and gap analysis
- Inform much needed changes to national datasets;

- **CCG Improvement and Assessment Framework** – Crisis and OATs prominent;
- Development of **Sustainability and Transformation plans** – new 5 year approach – including crisis and acute mental health;
- New **payment models** being developed for mental health and UEC
**CCG Improvement and assessment framework – crisis and acute care - ‘transformation indicators’**

**MH Liaison in acute hospitals**
1. Agreed & funded plan for ‘Core 24’ by 2020/21?
2. Agreed & funded plan for equivalent CYP crisis response?
3. Is the MH liaison an on-site 24/7 service?
4. 1 hr response times to ED, 24 hr to wards?
5. Routine outcome measurement?

**S.136 & health-based places of safety**
1. Use of police custody for s.136 assessments?
2. Use of data to monitor demand for HBPoS?
3. CCG signed up to a joint protocol with partners (MH Trusts, Police, LA)?
4. Instigate incident reviews when person cannot access health-based place of safety?
5. Do police have access to urgent specialist MH advice (e.g. street triage) ?

**Crisis Resolution & Home Treatment**
1. Agreed & funded plan for CRHTT to operate in line with recognised best practice?
2. 24/7 gatekeeping / rapid crisis response?
3. Adequate staffing / caseloads?
4. Intensive home treatment /therapeutic care?
5. Routine outcome measurement?

**Out of area treatments**
1. Can CCG measure OATs by bed type: number, reason, duration, cost of placements?
2. Does the CCG have a plan in place to reduce OATs in 2016/17 & eliminate by 2020/21?
3. Can the CCG demonstrate a reduction in OATs by the end of 2016/17?

More detail can be found at the CCG IAF technical annex P68-73 at the following link: [https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf](https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf)
Opportunities.....

- We now have a mandate via the MHTF - One of the **top 5 business priorities** for the NHS, as stated by Simon Stevens. A priority for the Prime Minister.

- Backed by **new money** from the Spending Review.

- Not just an ‘NHS’ issue – e.g. strong interdependencies with other partners e.g. housing, social care -

Challenges.....

- Mental Health system under severe pressure;

- **Workforce** – even with more money, is the workforce there to fulfil the national aims?

- Levers – getting standards, datasets and payment models align to **ensure that investment and services are done in the right way**
Horizon scanning ..... It’s a 10 year, not just a 5 year programme of transformation

For example..... most mental health care takes place in primary care or community mental health teams, or social care ........ yet these were less prominent in the Taskforce report, and in the Spending Review settlement

Therefore as well as delivering the ambitions of the MH Taskforce over the next 5 years, we must also try to build the evidence base, workforce and consensus on models of care for other areas of mental health so that by the time of the next Spending Review, we are in a position to bid for more funding where its needed

We must keep mental health at the forefront of public, policy, economic and political agenda
Primary Care

Recognition & referral
PC treatment

IAPT

Primary Care

Physical health, dental health

Community MH Care

Secure Care

Rehab Care

Acute Care

Crisis Care

Social Care + Housing + SMS + Vol Sector + Leisure

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Through the AMH programme we want …

- To **rebalance this system** (demand, capacity, spend) and make it work better for the people who use it and the people who work in it.
- People to have **timely access to evidence-based care, close to home** and in **least restrictive** (most enabling) settings.
- People to have **24/7 access to high quality care in a crisis.**
- Care to be **coproduced** in partnership with people who use services and for **hope, optimism and control** to be at the core of **values-based practice** across the AMH system.
- Care to be **integrated** – with primary care, with social care, with housing, with voluntary organisations and with wider community services.
- Achievement of **recovery-focused outcomes** to be what drives the system.
- **Commissioners to have the data, resources and skills** to be able to commission MH care that looks like this.
- To have the evidence we need, come the next SR, to make a **robust case for further investment.**
With some extra considerations...

The programme aims align strongly with the MHTF recommendations but our aims for AMH are slightly broader as we feel we must take into consideration how the recommendations can be implemented in the current context and how they can be implemented sustainably.

For example:

- We cannot eliminate OATS unless we can
  - (a) Reduce demand for acute care
  - (b) Improve flow through acute care
  
  This requires a focus on CMHS – the workforce, the interventions they are providing, their recovery focus and the way these services work with primary care, social care, housing, vol orgs and other local services.

- We cannot increase the intensity of CMHS interventions (in a context where caseloads have gone up by 20% in the space of a year) without
  - (a) additional funding (should we be looking at placements repatriation?)
  - (b) improved productivity (should we be looking at CPA and associated processes?)
  - (c) improved flow through CMHS (does it make any sense to continue to exclude primary care from our thinking about community mental health services?)

Without a focus on primary care and community mental health services – the parts of the system under greatest strain – we will not deliver our MHTF commitments. In developing our work programme we must have both:

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.... thank you and questions

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