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

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Adult Mental Health
Mental Health Clinical Policy and Strategy Team
NHS England
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4. Urgent and emergency mental health liaison in acute hospitals
1. Background and policy context:
Why is NHS England investing in mental health crisis & acute care?
Two key documents published in February last year which have shaped the National Crisis and Acute Care programme:

**Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England**
A report from the independent Commission on Acute Adult Psychiatric Care

**The Five Year Forward View for Mental Health**
A report from the independent Mental Health Taskforce to the NHS in England
Mental Health Task Force – acute mental health

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.

Recommendation 18:
• By 2020/21, **no acute hospital is without all-age mental health liaison services** in emergency departments and inpatient wards, and **at least 50 per cent of acute hospitals are meeting the ‘core 24’ service standard as a minimum**.

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.
Spending Review – Headlines for Crisis & Acute Care

“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) - **£69m is available through CCG baselines between 2017-2019**, distributed on a ‘fair shares’ basis. Indicative information suggests that this uplift is not all being spent on CRHTTs – *have you seen extra investment in your area?*

• **£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)
Upcoming national guidance on the acute and community crisis response and increased transparency

- During 2016/17 **multi-agency expert reference groups** – service managers, clinicians, experts by experience, commissioners, social care, policy managers, police, academics have followed a NICE-guideline type process to develop national policy guidelines for crisis & acute care.

- We will shortly be publishing **guides to support the local implementation** of evidence-based acute and crisis care with **accompanying helpful resources** and examples of how services are already delivering this care around the country.

- The guides contain a **clear set of access and quality benchmarks**, which when met, have been demonstrated to support the reduction of OAPs.

- The guides will be followed by an **England-wide Quality Assessment and Improvement Scheme** to identify current levels of service provision and support local improvement.

- **New data** items in the Mental Health Services data Set (MHSDS) will also provide increased transparency of activity across crisis and acute mental health services. **It is critical that providers, CCGs and STPs are assured of the data quality that is being submitted to the MHSDS locally.**
Crisis & acute now hard-wired and prioritised in many of the national levers - this has not been the case until now

✓ Year long **CCQI implementation support scheme** following publication of **new suite of national quality benchmarks and resources**

✓ **CCG Improvement and Assessment Framework** – including transformation indicators for U&E MH in 2016/17, crisis & acute indicators prioritised in 2017/18;

✓ **NHS Planning guidance**

✓ **Next Steps on FYFV document** – MH one of 4 priority areas

✓ **NHSI Oversight Framework** and **CQC ratings** to be based on new pathways;

✓ Aides memoires and assurances of **STPs** include U&E and acute MH;

✓ **MH Dashboard, CCG financial tracker** – specific returns and transparency on spend and provision of services;

✓ Changes to **national datasets** – MHSDS and ECDS; establishment of new national statistics

✓ **CQUINs** (Frequent attenders to A&E), **CCG Quality Premium** (out of area placements);

✓ **NHS England assurance and performance** functions
2. Crisis Resolution & Home Treatment Teams

FYFV Deliverable: By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that:

- a 24/7 community-based mental health crisis response is available in all areas

- these teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.
What should the whole system of urgent and emergency mental health care look like?

<table>
<thead>
<tr>
<th>24/7 urgent and emergency mental health response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis helpline available 24/7</td>
</tr>
<tr>
<td>Protocols in place with NHS 111 to transfer and signpost calls</td>
</tr>
<tr>
<td>NHS 111 up-to-date and complete directory of services</td>
</tr>
<tr>
<td>Single point of access, open to referrals from anyone including self-referrals</td>
</tr>
<tr>
<td>CRHTTs resourced with fidelity to model</td>
</tr>
<tr>
<td>Liaison mental health services at least in line with core 24 model</td>
</tr>
<tr>
<td>AMHP and MHA section 12 doctor rotas provide responsive service</td>
</tr>
<tr>
<td>All services adhere to the MHA Code of Practice</td>
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<tr>
<td>Agreed protocols and understanding of responsibilities under section 140 of MHA</td>
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<thead>
<tr>
<th>Use of IT</th>
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<tbody>
<tr>
<td>Enhanced electronic care records (e.g. SCRs), including crisis/care plans, that are easily accessible across all relevant services</td>
</tr>
<tr>
<td>Accessible advanced decisions and plans</td>
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<tr>
<td>IT systems capable of supporting efficient data submission</td>
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<thead>
<tr>
<th>Workforce and training</th>
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<tbody>
<tr>
<td>Training for non-specialist mental health professionals supporting an urgent and emergency response (police, ED, paramedics, fire fighters)</td>
</tr>
<tr>
<td>Close links (or embedded in team) to social workers, housing, employment, local Citizens Advice specialists, drug and alcohol services, or AMHPs</td>
</tr>
<tr>
<td>Specialist supervision to ensure staff wellbeing for the urgent and emergency mental health workforce</td>
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<thead>
<tr>
<th>Health inequalities</th>
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<tbody>
<tr>
<td>Collect and understand data on inequalities (e.g. race, gender, age, diagnosis, physical disability, homelessness, LGBTQ)</td>
</tr>
<tr>
<td>Co-produce the system with people who use it, putting particular focus on working with people who experience health inequalities</td>
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<tr>
<td>Adherence to the Equalities Act 2010</td>
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<tr>
<th>Primary care</th>
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<tbody>
<tr>
<td>Mental health awareness training for all primary care professionals</td>
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<td>Access to mental health professionals to give immediate advice to GPs in and out of hours</td>
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<th>Data collection and outcomes measures</th>
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<tr>
<td>CROMs, PROMs, PREMs</td>
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<tr>
<td>Data on triggers of crisis (including social triggers)</td>
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<tr>
<td>Response times to referrals</td>
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<tr>
<td>Delivery of NICE-recommended interventions and care</td>
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<td>Data on people who attend or call frequently or are detained repeatedly</td>
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<th>Places of safety</th>
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<tr>
<td>Avoidance of use of police cells</td>
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<tr>
<td>Age and developmentally appropriate (including suitable for children and young people)</td>
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<tr>
<td>Adherence to RCPsych clinical and physical standards for appropriate and safe environments</td>
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<th>Alternatives to attending ED</th>
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<tr>
<td>Crisis and respite houses</td>
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<tr>
<td>Third sector services</td>
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<tr>
<td>Community crisis response services for all ages able to attend people’s homes 24/7</td>
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<tr>
<td>Access to social care support, including assessment and support for carers</td>
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<th>Alcohol and substance use services</th>
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<tr>
<td>Access to and joint working with alcohol and substance use services as part of crisis response</td>
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<tr>
<td>Pathway to prevent exclusion of people who present in mental health crisis and are intoxicated</td>
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<th>Blue light services</th>
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<tr>
<td>Information sharing and joint working between mental health services and blue light professionals</td>
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<tr>
<td>Joint protocols for section 135 and 136 of MHA, including transport and local health-based places of safety</td>
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<tr>
<th>Children and young people’s services</th>
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<tbody>
<tr>
<td>Clear and specific 24/7 mental health crisis pathway for children and young people</td>
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<tr>
<td>Staff skilled in working with children and young people in crisis available 24/7</td>
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</table>
Crisis Resolution Home Treatment Teams (CRHTTs) – are your teams able to meet all key functions

- CRHTTs resourced to deliver their core functions in line with the evidence base are a key component of a well-functioning acute mental health system and have been shown to support the reduction of avoidable OAPs.

- Core functions include both an urgent and emergency community response and intensive home treatment, available 24/7:

  - Urgent and emergency community assessment provides:
    - accessible 24/7 care
    - rapid assessment in the community for urgent and emergency referrals
    - a gatekeeping function (managing access to inpatient beds)
    - initial treatment package (medical and brief psychological intervention)
    - management of immediate risk and safety.

The UCL Core study has a 39 point fidelity scale for teams to assess themselves against...
What do we know about access to CRHTTs – selected stats from UCL survey, 2016

Access and response times

- 45% have locally set targets to commence an assessment in under 4 hours
- 43% of teams are open to self-referral

### CRHTT 24/7 offers

<table>
<thead>
<tr>
<th>Service</th>
<th>PR</th>
<th>PSCSU</th>
<th>ANRNHS</th>
<th>ANRH</th>
<th>VCSAH</th>
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</thead>
<tbody>
<tr>
<td>Adult referral</td>
<td>92.6</td>
<td>91.1</td>
<td>84.7</td>
<td>67.4</td>
<td>69.5</td>
</tr>
<tr>
<td>Phone referral</td>
<td>PR</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Phone Support to current CRHTT</td>
<td>PSCSU</td>
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<tr>
<td>Service Users</td>
<td>ANRNHS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Assessment of new referrals on NHS premises</td>
<td>ANRH</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Assessment of new referrals at home</td>
<td>VCSAH</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Visit current CRHTT Service Users At Home</td>
<td>VCSAT</td>
<td></td>
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Upcoming benchmarks: community crisis response

• the urgent and emergency mental health service should provide the person who contacted the service with an update/feedback on care and support to be provided – usually within an hour.

• For some people telephone advice may be sufficient to address their needs, and will allow the service to prioritise face to face assessment for people who need it;

• Within 4 hours of a request for help, people with emergency needs should have been provided with an assessment and have an urgent and emergency mental health care plan in place (the assessment should be biopsychosocial, but if this is not possible, an initial face-face crisis assessment should be undertaken as a minimum), and

  - been accepted and scheduled for follow-up care by an appropriate service (this could include support provided at home),
    or
  - been discharged because the crisis has resolved; or
  - started an assessment under the Mental Health Act.

• If a person cannot be seen within 4 hours because of the unpredictable nature of crisis services, the person should know within an hour when they will be seen and the reason for any delay.

• At times when demand exceeds capacity, services should prioritise crisis response based on clinical need or risk
Draft access and quality benchmarks: crisis responses – what is NICE recommended care?

- As well as the initial emergency response to a crisis within 4 hours, services should ensure continuity of ongoing care outside of the 4-hour response (this could include further assessment if necessary, for example to complete a biopsychosocial assessment if this was not possible within 4 hours)

- Professional should ensure that they:
  - provide a kind, compassionate and empathetic response
  - plan for the short-term safety of the person, if necessary
  - undertake an initial risk assessment
  - plan appropriate observations for both mental and physical health
  - access any existing mental health Plan, where available
  - notify the local authority if the person is an ‘at risk’ adult or older adult.

What is NICE-recommended crisis care?

1. Biopsychosocial assessment: an assessment of mental, physical and social needs (see the appendices and helpful resources to the full implementation guidance for more information on what is included in a biopsychosocial assessment).

2. Urgent and emergency mental health care plan: a plan created with the person experiencing a crisis, and their family or carer if appropriate, to manage the immediate crisis situation (see the appendices and helpful resources for information on what this plan should include).

3. A focus on service user experience: outcomes and experience measures adapted from NICE Service User Experience in Mental Health guideline (see the appendices and helpful resources for suggested outcomes and experience measures).
Case studies: well performing CRHTTs meeting core functions

• Sunderland **Initial response service** with big focus on reducing clinician admin including digital dictation service that clinicians credit as key enabler of successful service

• Bradford **First Response service, Haven** – whole system approach including acute, community, social care and police services

• **Cambridge & Peterborough** has replicated Bradford crisis model, including **Sanctuary** - mental health attendances at all three EDs in the area have reduced by 20%
Case studies: well performing CRHTTs meeting core functions

2gether NHS Foundation Trust: Hereford Crisis Assessment and Home Treatment Team

Central and North West London NHS Foundation Trust: Westminster Older Adults Integrated Community Mental Health and Home Treatment Team

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH): CRHTTs
3. Acute mental health care, inc. out of area placements

FYFV Deliverables:

- the practice of sending people out of area for acute inpatient care due to local acute bed pressures eliminated entirely by no later than 2020/21

- standards for acute care introduced

- full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists
Draft benchmarks: time from decision to admit to admission

• Any person requiring acute mental health care in a community-based setting should have their first face-to-face contact to begin evidence based care within a day of referral.

• Any person requiring acute mental health care in an inpatient setting should receive orientation onto the ward as well as verbal and written information about who their named care team will be within 4 hours of referral.

However…..

• We need to consider perverse consequences while acute mental health system is over 100% capacity and people being sent out of area.

• However, once this is addressed and there is always bed capacity in a local system, timely access should become more straightforward to achieve.
9 core principles for acute mental health care (inpatient and community)

**Upon admission**
1. A comprehensive physical health assessment at the start of treatment;

**Within 2-3 days of admission**
2. A care plan to be initiated
3. A Care Act-compliant assessment to be completed to identify any social care issues
4. The discharge destination to be considered for those who have housing needs

**Throughout episode of care**
5. Access to daily meaningful and recovery-focused activities while receiving care
6. One-to-one face-to-face time with a care professional that the person knows, every day
7. Feedback on service experience to be sought to improve the delivery of care
8. Review of physical health care needs as necessary

**Post discharge**
9. Follow-up after discharge from an acute mental health inpatient setting to be made within 2 days.
Eliminating acute mental health out of area placements (OAPs)

• In their reports published last year, both the Commission on Acute Adult Psychiatric Care and the Mental Health Task Force called for an end to the practice of sending acutely ill people long distances for treatment, which leads to poor patient experience, outcomes and unnecessary costs to the NHS.

• We have **committed to eliminating the practice completely by 2021** for those requiring non-specialist acute care.

Out of area placements are an indicator of a whole mental health system under pressure, not simply the result of too few acute mental health beds.
## Headline Data Q1 2017/18

<table>
<thead>
<tr>
<th>Region</th>
<th>Inappropriate OAPs started in period</th>
<th>Total no. of OAP days over the period</th>
<th>Total recorded costs over the period</th>
<th>No. of OAPs that ended in the period with a length of 31 or more nights (1)</th>
<th>No. of OAPs active during the period with a distance of 100km or greater</th>
<th>Average recorded daily cost over the period (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1,810</td>
<td>64,896</td>
<td>£24,461,200</td>
<td>371</td>
<td>575</td>
<td>£540</td>
</tr>
<tr>
<td>North</td>
<td>445</td>
<td>15,569</td>
<td>£3,166,770</td>
<td>95</td>
<td>90</td>
<td>£515</td>
</tr>
<tr>
<td>Mids &amp; East</td>
<td>420</td>
<td>16,665</td>
<td>£6,780,220</td>
<td>75</td>
<td>130</td>
<td>£525</td>
</tr>
<tr>
<td>London</td>
<td>400</td>
<td>12,414</td>
<td>£6,565,510</td>
<td>90</td>
<td>40</td>
<td>£530</td>
</tr>
<tr>
<td>South</td>
<td>525</td>
<td>18,436</td>
<td>£7,244,240</td>
<td>110</td>
<td>205</td>
<td>£580</td>
</tr>
<tr>
<td>Unknown</td>
<td>20</td>
<td>1,812</td>
<td>£704,492</td>
<td>-</td>
<td>10</td>
<td>£540</td>
</tr>
</tbody>
</table>

- The regional data in this table for ‘Inappropriate OAPs started in period’ is subject to NHS Digital’s suppression rules - counts have been rounded to the nearest five.
- (1) Only includes OAPs that ended during June and that started on or after the 17th October 2016.
- (2) Recorded Cost – since January cost has only been recorded where a provider has been charged by a different organisation for making the placement. (There are some scenarios where an OAP may take place within a provider organisation where the provider covers a very large geographical patch). As such the costs reported for 2017 should not be compared with those in 2016.
OAPs to NHS and Independent Sector Providers (Feb, Mar, Apr 2017)

<table>
<thead>
<tr>
<th></th>
<th>OAPs started in period</th>
<th>Total no. of OAP days over the period</th>
<th>Total recorded costs over the period</th>
<th>No. of OAPs that ended in the period with a length of 31 or more nights (1)</th>
<th>No. of OAPs active during the period with a distance of 100km or greater</th>
<th>Average recorded daily cost over the period (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>583</td>
<td>22,147</td>
<td>£4,224,580</td>
<td>111</td>
<td>68</td>
<td>£530</td>
</tr>
<tr>
<td>Private</td>
<td>1,285</td>
<td>45,403</td>
<td>£20,938,500</td>
<td>270</td>
<td>538</td>
<td>£540</td>
</tr>
</tbody>
</table>

- The table shows that:
  - over two-thirds of all OAPs are to private sector beds
  - these placements account for over 80% of the recorded costs
  - they also tend to have longer lengths of stay
  - require people to travel further from their homes (almost 8 times more likely to travel over 100km).
Case studies: Eliminating OAPs through whole system management

- Sheffield — blog from clinical lead, Dr Mike Hunter — now associate national clinical director at NHS Improvement. Further detail can be found [here](#).

- North East London Foundation Trust — NELFT has eliminated out of area placements for many years, with one of the lowest bed bases in the country - through investment in community services and intensive focus on acute pathway management.

- Leeds and York Partnership NHS FT: Efforts underway in ‘Leeds mental health flow’ project with write up of how the whole system is coming together to reduce out of area placements to save £1.5m for the local health economy.

- Bradford: adopted an approach with similar principles to Sheffield. Highlights include:
  - Vital partnership working with social care and local authority services to reduce delayed transfers of care, mental health act detentions, admissions and recovery in the community
  - Whole system approach to eliminating out of area placements in Bradford.
  - Focus on acute inpatient ward flow, DTOCs, including a 10 point discharge tracker (below):
Key questions for local systems seeking to address OAPs - taken from areas who have successfully transformed their acute mental health systems

Whole system priority
1. Agreement at all levels that OAPs are a priority / Board-level responsibility
2. Clinical and/or Service Director who is personally responsible
3. Whole system coming together in partnership to redesign pathways and agree processes – inpatient staff, CRHTTs, social care, AMHPs, CMHTs, voluntary sector, patients, IAPT, primary care
4. Financial risk/benefit sharing agreement between providers and commissioners
5. Long-term planning – whole system transformation may take over 2 years to sustainably and safely eliminate OAPs

NHS and LA service provision
6. Strengthened core community mental health services
7. Ensuring a system-wide approach to 24/7 crisis and home treatment services that interface with key external stakeholders, particularly A&E, police and ambulance
8. Investing in alternatives to admission through innovative models such as crisis recovery cafes and intensive home-based services.
9. Well resourced, personalised social care packages, AMHPs integrated with NHS teams
10. Housing, including specialist supported housing for mental health

Intensive focus on pathways, length of stay, bed management, patient ‘flow’
11. Admissions are therapeutic and purposeful (not simply risk-driven ‘containment’)
12. Discharge supported by high quality community services that are engaged in discharge planning from the point of admission
13. Use of real time data, including info on bed availability, capacity of HTTs, alternatives
14. Info on patients who have passed discharge dates, reviews / new discharge dates
15. Principle that bed / HTT must always be available where that is the right choice - similar bed management approach to HTT as for inpatient beds
Further positive practice case studies: acute care

- East London NHS Foundation Trust [Tower Hamlets acute mental health service](#)
- Camden and Islington NHS FT, [Drayton Park Women’s Crisis House](#)
- Mersey Care NHS FT has introduced [No Force First](#), an award-winning restraint reduction initiative.
- South London and Maudsley NHS FT [Gresham Unit Carers’ initiative](#)

Addressing inequalities in acute mental health

Resources from Joint Commissioning Panel on mental health for people from:
- BAME backgrounds,
- older people
- learning disabilities
- physical health needs

Case study: [African Caribbean Community Initiative](#), Wolverhampton
Mental health rehabilitation service examples

- Cheshire and Wirral Partnership NHS Foundation Trust, Complex Recovery Assessment and Consultation service that has contributed to the elimination of out of area placements
- Cornwall Partnership NHS FT, Fettle House rehabilitation service
- Northumberland Tyne & Wear NHS FT Rehabilitation and Recovery Services

Mental health supported housing examples

- St Martin of Tours Housing Association, Islington
- Living Well, South Yorkshire Housing Association
4. Acute Hospital Urgent & Emergency Liaison Mental Health

FYFV Deliverables:

- introduce access and quality standards for crisis care

- 50% of acute hospitals at core 24 standard for adults by 2020/21
Core 24 acute hospital urgent & emergency liaison mental health: the basics

- Proven **clinical benefits**: NICE-recommended care, expert, compassionate response, better patient experience, care planning and links to community mental health services, identify and treat (many) underlying mental health needs of physical health presentations in acute hospitals

- Proven **financial / productivity benefits**: reduced length of stay, reduced emergency admissions via A&E, reduced A&E re-attendance rates

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National definition of ‘Core 24’ – minimum ambition for all acute hospitals with 24/7 A&E departments:

- **24/7** hours of operation;
- **1hr response** times to emergency referrals from ED, **24hr response** to urgent ward referrals;
- **Staffed** in line with or close to recommended levels to cover 24/7 rota, including access to older adult expertise;
- Funded recurrently – **this is now a minimum, no longer a ‘pilot’ service.**
Wave 1 bidding process now complete:

- 17 hospitals already at Core 24 (10%)

- £30m funding to 74 acute hospital sites to achieve ‘Core 24’ from 2017-2019

- By 2019 – 81 aim to have achieved Core 24 standard
National quality benchmarks for urgent and emergency liaison mental health – recommended response times and interventions

- Within a **maximum of 1 hour** of a liaison mental health service receiving an emergency referral, any person experiencing a mental health crisis receives a response from the liaison team (aka an ‘urgent and emergency mental health service’)

- Response within **24 hours for urgent referrals from wards**

- **Within four hours** (NB works within existing 4hr A&E standard) from arriving at ED/being referred from an acute general hospital ward, I should:
  - have received a full biopsychosocial assessment and jointly created an urgent and emergency care plan, or an assessment under the Mental Health Act should have started;
  - have been accepted and scheduled for follow-up care by a responding service;
  - be en route to next location if geographically different; or
  - have been discharged because the crisis has resolved.

- Quality as important in terms of delivering evidence-based NICE-concordant care & outcomes measurement

- NHSE, NICE, NCCMH implementation guidance and helpful resources (right click to open hyperlinks)
.... thank you and questions

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