Urgent & Emergency Mental Health Care: national update

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HC-UK conference
Manchester, 6 December 2016
CQC thematic review summer 2015:

✓ 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**
Mental Health Task Force (Feb 2016) – 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 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:
  - 2016/17 - **crisis care** (under development)
  - 2016/17 – **acute mental health care** (under development)
“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);

- **£249m 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)
Programme scope

Crisis Care – urgent/emergency crisis response - (underway, phase 1)
✓ Primary care response (in and OOH)
✓ 111 (and the DoS; IUC) and 999
✓ 24/7 MH crisis line (tele-triage & tele-health) and 24/7 community-based crisis response (CR)
✓ ‘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)

Within the scope of UEC payment model(s)

Acute Care - (underway, phase 2):
• Alternatives to admission – crisis & respite houses, family placements
• 24/7 intensive home treatment as alternative to admission (HT)
• 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...
Development of new pathways and standards

National focus in 2016/17 on ‘preparatory’ national work before new money comes in – the national levers and incentives to support local delivery from 2017/18:

Develop 4x projects for UE mental health:

- 24/7 UE liaison MH in acute hospitals – NOW PUBLISHED!
- 24/7 ‘blue light’ UE MH response – Dec
- 24/7 community UE MH response – spring ‘17
- 24/7 UE MH response for children and young people – Dec

For each of the above, Expert Reference Groups to advise on/recommend:

✓ Referral to treatment pathway, including response times and NICE quality standards
✓ Implementation guidance
✓ England-wide quality assessment and improvement scheme
✓ England-wide baseline audit & gap analysis
✓ Articulate key national metrics to measure pathways
Recommended response times for urgent and emergency liaison mental health

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

- Within **four hours** 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

- Other pathways equivalent approach – learning from the past in terms of incentivising the right system behaviours
What constitutes NICE-concordant care for people with urgent and emergency mental health needs? Measures taken from NICE service user experience guideline

<table>
<thead>
<tr>
<th>Statement</th>
<th>Please circle one number</th>
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<tbody>
<tr>
<td>If I experience a mental health crisis again, I feel optimistic that care will be effective.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>During the treatment for my crisis, I was treated with empathy, dignity and respect.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>During the treatment for my crisis, I felt actively involved in shared decision-making and supported in self-management.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>I feel confident that my views are used to monitor and improve the performance of mental health care for crises.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>I can access mental health crisis services when I need them.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>During the treatment for my crisis, I understood the assessment process, diagnosis and treatment options, and received emotional support for any sensitive issues.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>During the treatment for my crisis, I jointly developed a care plan with mental health and social care professionals, and was given a copy with an agreed date to review it.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>When I accessed crisis support, I had a comprehensive assessment, undertaken by a professional competent in crisis working.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>The mental health crisis team considered the support and care needs of my family or carers when I was in crisis. Where needs were identified, they ensured that they were met when it was safe and practicable to do so.</td>
<td>1 2 3 4 5</td>
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Clinician reported outcome measure

Clinical Global Impression Improvement Scale (CGI-I)

<table>
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<tr>
<th>Compared to the person’s condition at the start of assessment, his/her condition is:</th>
</tr>
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<tr>
<td>Very much improved</td>
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<td>1</td>
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- Guide also references FROM-LP
- FROM-LP II in development – endgame is to develop an agreed, validated CROM for liaison
Other key points from Urgent & Emergency Liaison MH implementation guidance – READ IT!!

- >18s i.e. adults & older adults

- **Scope is UEC.** We know liaison is much more than that; planned care liaison separate & forthcoming further down line

- Sets out **important functions** of liaison mental health services in responding to mental health crises & benefits

- Information on **staffing & skill mix** necessary to deliver care in line with NICE guidance

- Describes **optimal service models**

- Clarifies **data collection and reporting requirements**

- Aims to provide a **step-by-step process** that local commissioners and providers can follow, working collaboratively with stakeholders, to **ensure sustainable delivery** of the evidence-based treatment pathways

- Separate **Positive Practice Examples and Helpful Resources** pack published simultaneously
UE MH care in other national levers and incentives

- CCG Improvement and Assessment Framework – UE MH care prominent
- NHS Planning Guidance – among 2 of the 9 NHS ‘must dos’
- NHSI Single Oversight Framework
- Aides-memoires and assurances of STPs
- MH Dashboard, CCG Financial tracker (MH Investment Standard)
- Much needed changes to national datasets
- CQUINs, Quality Premiums, new payment models for UEC and MH
- NHS England assurance and performance functions
- Year long CCQI implementation support scheme following publication of new suite of national guidance documents
Quality assessment and improvement scheme for UE MH care – College Centre for Quality Improvement (CCQI; RCPsych)

Purpose:
- Communicate and familiarise all NHS crisis services with the new recommended standards set out in the implementation guides;
- Measure – self-assessment against key criteria;
- Receive feedback and support from CCQI to identify key gaps;
- Provides national understanding of performance of services – allowing for a baseline audit and gap analysis for crisis care.

We are ambitious realists!

Role of local Concordat groups:
- Aimed at NHS services across all 3 pathways (liaison MH, ‘blue light’, community crisis response; CYP separate)
- We envisage a central role for key partners in local Crisis Care Concordat Groups in signing off self-assessment returns
- England-wide scheme launched around spring 2017 for one year
Children and young people’s crisis care

• All areas asked to invest and develop CYP crisis care as part of their Local Transformation Plans, in Future in Mind

• NHS England has commissioned an evidence-based treatment pathway project for CYP crisis care

• Central pump prime investment (£4m) in an accelerator programme for urgent & emergency mental health care for CYP to the 8 UEC Vanguards for rapid testing and evaluation of different models of CYP crisis care. Some examples of potential models include:

  • **Model 1:** Collaboration between a number of specialist community mental health services
  • **Model 2:** Hub and spoke model: collaboration between children and young people’s specialist tier 3 and tier 4 community and inpatient mental health services
  • **Model 3:** Integrated CYP mental health and social care
  • **Model 4:** All-age integrated liaison and crisis mental health intervention
Linking up governance – much work already underway on MH crisis

- 90+ local multi-agency Crisis Care Concordat groups have been developing & implementing action plans to improve MH crisis care since autumn 2014

- Most regions (if not all) will have networks in place to support improvements in mental health liaison and crisis care

- These CCC groups have expertise, experience, ideas and plans already underway. They have created and nurtured relationships among the key public and voluntary sector partners which we want to build on

- Transformation of MH crisis care must be seen and integrated within wider UEC system transformation – both are complementary

- Link-up vital: Networks/PMOs unfamiliar with local MH work should join with CCC groups, NHSE MH regional leads, MH Clinical Networks
8 Key Elements of Integrated Urgent Care

- Mental Health

A single call to get an appointment out-of-hours (OOHs)

The summary care record is available in the clinical hub and elsewhere

Data can be sent between providers

Care plans and patient notes are shared between providers

Appointments can be made to in-hours GPs

There is joint governance across local urgent and emergency care providers

There is a clinical hub containing (physically or virtually) GPs and other health care professionals

Including MH care & crisis plans... interoperable/integrated electronic records?

Is MH adequately represented within overall UEC governance?

Including MH professionals for advice, warm handovers...

What are OOH referral options if someone is in MH crisis?

Including MH providers...
UE liaison mental health transformation fund 1/2

£30m pump prime funding for 2017/18 & 2018/19 (£15m each) as ‘Wave 1’

- Objective: at least 50% of acute hospitals (with 24/7 A&Es) at ‘Core 24’ for adults by 2021

- NHS England determines that a liaison MH service is at ‘Core 24’ based on the following three criteria:
  
  - Teams are commissioned to operate on a 24/7 basis
  - Teams are resourced in line with (or close to) the recommended staff numbers and skill mix (including access to older adult clinical expertise) to operate effectively on a 24/7 rota
  - Teams are meeting recommended response times following referral (1hr for emergency referrals, 24hrs for urgent ward referrals).

- Currently only 10% meet all 3 criteria. This fund will help increase this number and move us towards desired 50%
Wave 1 focus on pump prime funding to accelerate existing local development plans for those closest to achieve the ‘Core 24’ service level

A&E Delivery Board(s) footprints with support from regional UEC PMOs and UEC Networks; aligned with STP plans

Liaison one of clearest signals that MH is core business for + clear part of acute sector & wider UEC system

Looking for strong senior clinical and operational leadership, strong joint governance between CCGs, acute trusts, mental health trusts and other partners

Gradual expansion of workforce required over medium/longer term

Wave 2 (2018) likely to therefore have greater overall funding.

In the interim, services currently further away from Core 24 should develop and implement robust, locally funded improvement plans to move closer to the Core 24 standard and maximise their chances of successfully bidding for Wave 2 transformation funding
New CQUIN: Improving services for people with mental health needs who present to A&E

- Completeness and quality of A&E diagnostic coding is known to be highly variable, and on the whole still needs considerable improvement. Particularly true for MH – primary & secondary presentations. E.g. 1 million MH presentations?? + Anecdotes about 4hr A&E breaches but little data ∴ little evidence to make investment case

- Two-year CQUIN therefore major focus on improving quality of coding of primary & secondary MH needs in A&E (longer term ECDS work with RCEM)

- Additional focus on:
  - identifying top frequent A&E attenders who would benefit most from specialist MH interventions
  - reviewing/developing joint multi-agency, co-produced care plans
  - strengthening existing/developing new services to support this cohort of people better and offer safe and more therapeutic alternatives to A&E where appropriate
  - reduce the number of attendances to A&E for those frequent attenders and all people with primary MH needs and establish improved services to ensure reductions are sustainable.

- Final version published at beginning of November following engagement and refinement
.... thank you...

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