

Urgent & Emergency Liaison Mental Health Care in Acute Hospitals: National Policy Perspective

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***CCQI PLAN event
RCPsych, 3 March 2017***



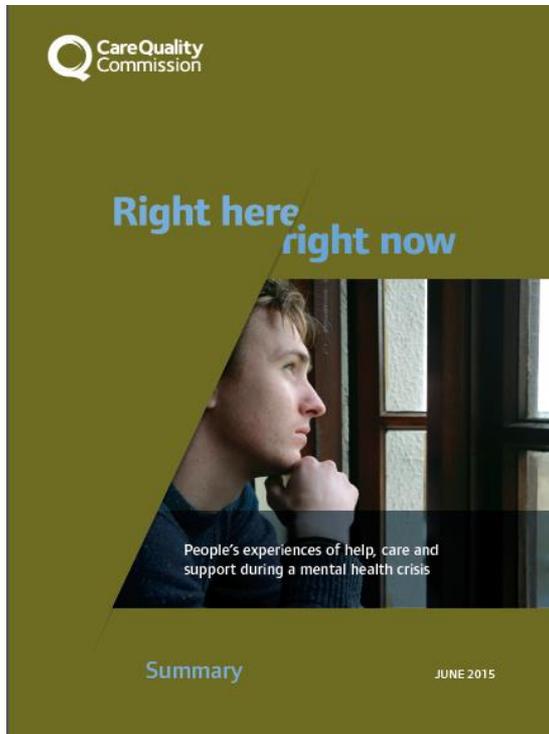
Mental Health Crisis
Care Concordat
Improving outcomes
for people experiencing
mental health crisis

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 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.



A report from the independent Mental Health Taskforce to the NHS in England
February 2016

Mental Health Task Force – crisis recommendations (continued, 2/2)

Recommendation 13:

- Introduce a range of access and quality standards across mental health. This includes:

- 2016/17 - **crisis care** (under development)

...which we are now calling **urgent and emergency mental health care**

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);
- **£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

USE OF DIGITAL TECHNOLOGY

SELF MGT & CARE PLANNING

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)

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*

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 – spring '17
- 24/7 community UE MH response – spring '17
- 24/7 UE MH response for children and young people – spring '17

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

Achieving Better Access to 24/7 Urgent and
Emergency Mental Health Care – Part 2:
**Implementing the Evidence-based Treatment
Pathway for Urgent and Emergency Liaison
Mental Health Services for Adults and Older
Adults – Guidance**

Liaison Mental Health
Services for Adults
and Older Adults

NATIONAL
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CENTRE FOR
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Achieving Better Access to 24/7 Urgent and
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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

	Statement	Please circle one number				
1	If I experience a mental health crisis again, I feel optimistic that care will be effective.	1	2	3	4	5
2	During the treatment for my crisis, I was treated with empathy, dignity and respect.	1	2	3	4	5
3	During the treatment for my crisis, I felt actively involved in shared decision-making and supported in self-management.	1	2	3	4	5
4	I feel confident that my views are used to monitor and improve the performance of mental health care for crises.	1	2	3	4	5
5	I can access mental health crisis services when I need them.	1	2	3	4	5
6	During the treatment for my crisis, I understood the assessment process, diagnosis and treatment options, and received emotional support for any sensitive issues.	1	2	3	4	5
7	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.	1	2	3	4	5
8	When I accessed crisis support, I had a comprehensive assessment, undertaken by a professional competent in crisis working.	1	2	3	4	5
9	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.	1	2	3	4	5

Clinician reported outcome measure

Clinical Global Impression Improvement Scale (CGI-I)

Compared to the person's condition at the start of assessment, his/her condition is:

Very much improved	Much improved	Minimally improved	No change	Minimally worse	Much worse	Very much worse
1	2	3	4	5	6	7

- 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 – **(please) READ IT!!**

- >18s i.e. **adults & older adults**
- **Scope is UEC but we know liaison is much more than that;** those teams in hospitals at core 24 or higher service standard are able to work with ward inpatients & in planned pathways. **Separate guidance for planned liaison care and integrated IAPT currently in development with publication planned for 2017**
- 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



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%

UE liaison mental health transformation fund 2/2

- **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
- **Significant interest** – high quality bids received covering 80 acute hospitals across 36 STP footprints
- Regional teams forwarded final bids for consideration to national team. **National expert panel meeting 6 Feb** → recommendations to NHS England Investment Committee which met on **23 Feb**
- Successful and unsuccessful bidders will be notified **this month (March)**
- Even for those unsuccessful, this process will help to ensure **excellent preparedness for Wave 2** funding (£90m) which will become available in autumn/winter 2018 – time for development over 2017/18 and 2018/19

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 2016 following engagement and refinement

Suicide prevention and self harm care in acute hospitals

Public Health England

Supported by
National Suicide Prevention Alliance

Protecting and improving the nation's health

Local suicide prevention planning

A practice resource

October 2016

The cover features a dark red background with a cluster of white icons including a cross, a clock, a location pin, a document, a magnifying glass, a speech bubble, a gear, and a group of people.

House of Commons
Health Committee

Suicide prevention: interim report

Fourth Report of Session 2016–17

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 13 December 2016

HC 300
Published on 19 December 2016
by authority of the House of Commons

HM Government

Preventing suicide in England:

Third progress report of the cross-government outcomes strategy to save lives

January 2017

Self harm care in acute hospitals – some stats

- [Hawton and colleagues \(2007\)](#) estimated there were **220,000 episodes** dealt with by hospitals in England each year
- However, a more recent study (Clements et al., 2016) suggested that there is a **consistent significant underestimation** of presentations for self-harm recorded by HES Emergency Department data – **by approximately 60%**
- Approximately **one in five** people who attend an emergency department following self-harm will harm themselves **again in the following year** ([Bergen et al., 2010](#)); a small minority of people will do so **repeatedly**

Self harm care in acute hospitals – hard facts

- Self-harm is associated with an **extremely high mortality risk**, including from physical health issues (Bergen et al., 2012)
- **The risk of suicide is elevated by between 30- and 100-fold in the year following self-harm (Hawton et al., 2003; Cooper et al., 2005)**
- **Self-harm is also a key risk factor, and the strongest predictor, for suicide (Sakinofsky, 2000)**

Self harm care in acute hospitals – more facts

- Providing a psychosocial assessment to those who present to A&E having self-harmed has long been part of national guidance (NICE) and there is **evidence that doing one reduces the risk of future self-harm** (Hickey, 2001) – it can start a therapeutic relationship with the healthcare professional and be used to form an effective management plan
- Psychosocial assessment is beneficial in reducing repeated self-harm in people **both with and without** a history of psychiatric care

Self harm care in acute hospitals – notable facts

- A recent systematic review of risk factors and risk scales (Chan et al., 2016) concluded that the evidence points to a **comprehensive psychosocial assessment of the risks and needs that are specific to the individual as the only clear intervention central to the safe management of people who have self-harmed**
- Nielssen et al (2017):

*...since risk assessment cannot be a practical basis for interventions aimed at reducing suicide, the alternative is for ...services to carefully consider what amounts to an **adequate standard of care**, and to adopt the universal precaution of attempting to provide that to all...patients.*

...AND YET...

Self harm care in acute hospitals – worrying facts

The proportion of self-harm episodes following which patients received a psychosocial assessment from a specialist has shown **little change**

This is despite guidance from NICE that an assessment should be conducted in all cases. The latest research suggests that still **only 53%** of people who self-harm and present to Emergency Departments receive a psychosocial assessment by specialist mental health staff (Geulayov et al., 2016)

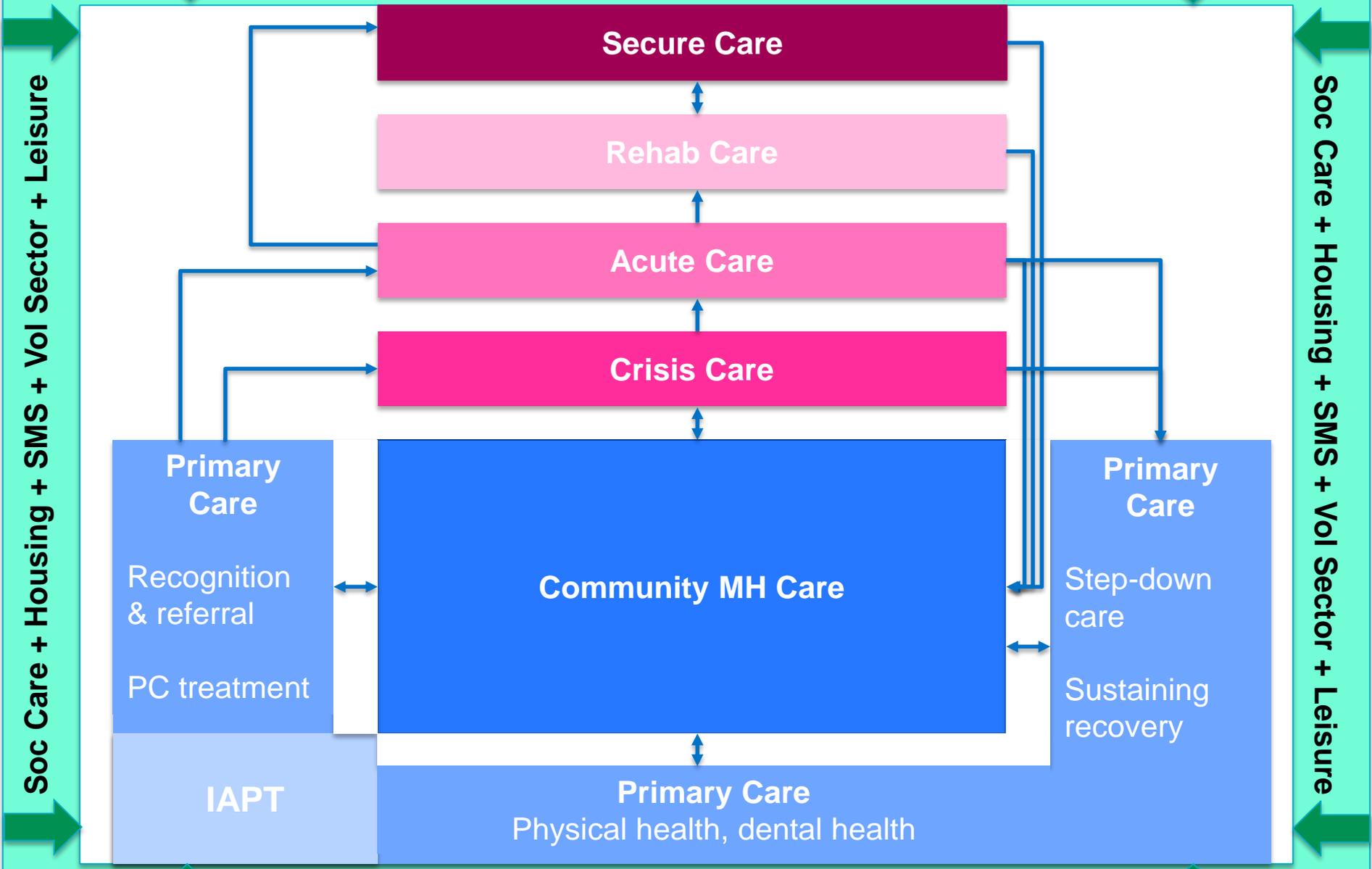
So – what is the relation of all of this to liaison?

- According to LPSE-3, almost all existing urgent and emergency liaison mental health teams provide self-harm care in acute hospitals
- They make a direct contribution to improving self-harm care through:
 - a) the provision of skilled, evidence-based psychosocial assessments
 - b) educating and training acute staff.
- Timely referrals between A&E staff and liaison staff are vital in optimising the care of people who self-harm and present to A&E – there is no such thing as ‘medically fit’ or ‘medically cleared’!

Linking up governance and ‘systems thinking’

- UE liaison is **one part of a wider system of care**
- Based in the acute hospital but **interfaces with other primary and secondary mental health services vital** – patient journey and patient experience throughout that journey
- **Active clinician and patient involvement in designing those systems and pathways is critical**
- Transformation of MH crisis care **must be seen and integrated within wider UEC system transformation** – both are complementary
- Many opportunities to **link up regional/local support** through NHS England structures, clinical networks, UEC Networks, STP workstreams, CCC groups

Social Care + Housing + SMS + Vol Sector + Leisure

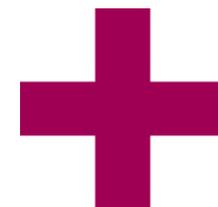
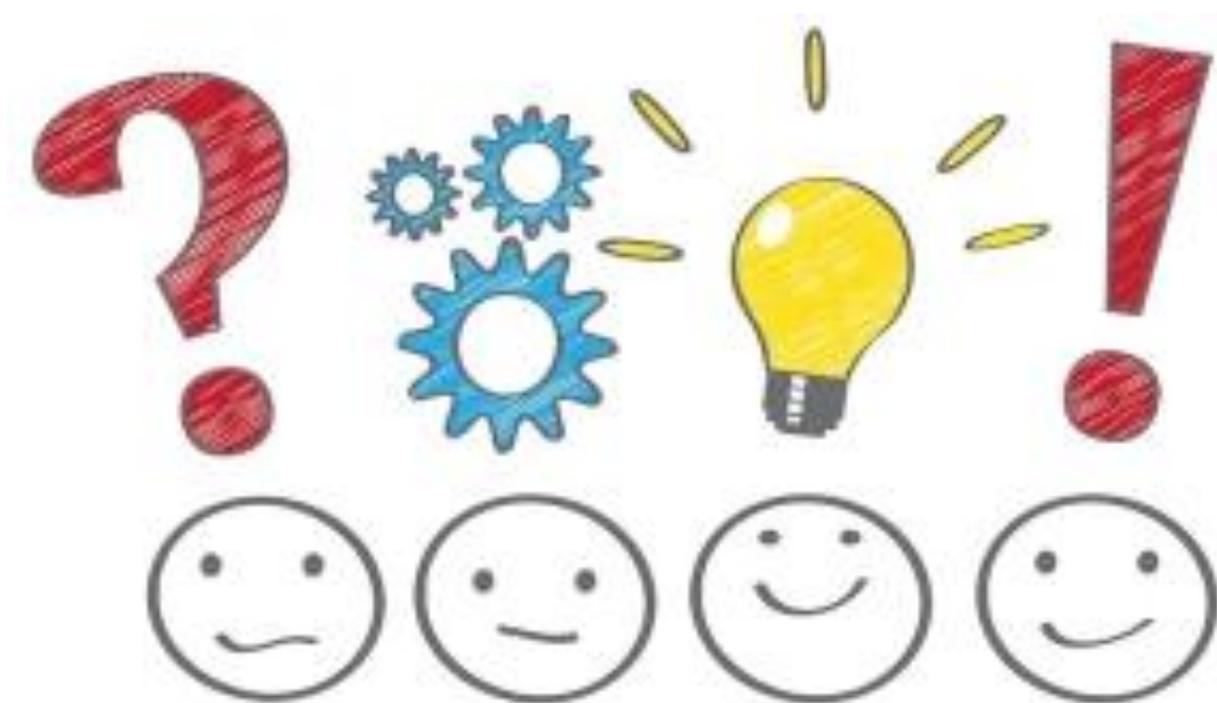


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Questions and discussion





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