Improving the therapeutic offer from acute inpatient mental health services

National update

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Mental health in the Long Term Plan – an overview

NHS

At the beginning of the year, the NHS Long Term Plan renewed our commitment to pursue the most ambitious transformation of mental health care England has ever known. Our headline ambition is to deliver 'world-class' mental health care, when and where children, adults and older adults need it.

The NHS Long Term Plan published on 7 January 2019 commits to grow investment in mental health services faster than the overall NHS budget. This creates **a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24**. Further, the NHS made a new commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. This will support, among other things:

- Significantly **more children and young people from** 0 to 25 years old to access timely and appropriate mental health care. NHS-funded school and college-based Mental Health Support Teams will also be available in at least one fifth of the country by 2023.
- People with **moderate to severe mental illnesses** will access better quality care across primary and community teams, have **greater choice and control** over the care they receive, and be supported to lead fulfilling lives in their communities.
- We will **expand perinatal mental health care** for women who need specialist mental health care during and following pregnancy.
- The NHS will provide a single-point of access and timely, age-appropriate, **universal mental health crisis care** for everyone, accessible via NHS 111.

NHS

The NHS Long Term Plan

#NHSLongTermPlan
www.longtermplan.nhs.uk
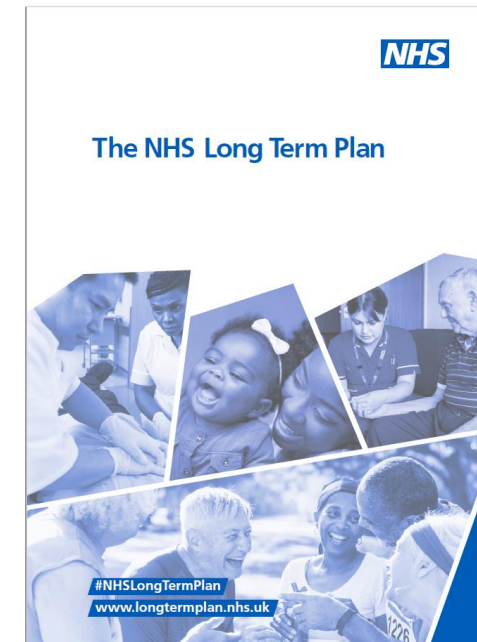
NHS Long Term Plan: commitments on crisis and acute mental health

1. **Universal 3-digit national number so that anyone experiencing mental health crisis can call NHS 111** and to open access, 24/7 age-appropriate mental health support**.**

2. Access to local crisis services through **NHS.UK website** postcode search

3. Continue ambition to ensure that all **adult and older adult community crisis resolution and home treatment services** are resourced and operating with high fidelity by 20/21

4. Ensure that by 2023/24, **70% of Mental Health Liaison services in acute hospitals meet the 'core 24' standard for adults and older adults**, working towards 100% coverage thereafter.

5. Increase provision of **crisis alternatives to A&E** such as crisis cafes and sanctuaries and **crisis/acute alternatives to inpatient admission** in acute mental health pathways, such as crisis houses and acute day services

6. Improve **ambulance response to mental health crisis** by: introducing **mental health transport vehicles** *(subject to capital settlement),* introducing **mental health professionals in 111/999 control rooms**; and **training / education** in mental health

7. Specific **waiting times targets for urgent & emergency mental health services will be field tested** (part of clinical review of standards)

8. Improve the **therapeutic offer on inpatient wards,** e.g. more psychologists and occupational therapy

9. Eliminate **out of area placements** for adult acute care

10. Implement the recommendations of the **Mental Health Act Review** and possible White Paper and Bill

11. **Capital funding to improve the mental health estate** *(subject to future capital funding settlement)* including inpatient wards, places of safety, crisis cafes, houses, A&E assessment spaces, ambulance vehicles

12. All **children and young people** will have access to **24/7 crisis, brief intervention and home treatment services** by 2023/24

13. Full coverage across the country of the existing **suicide reduction programme.**

14. Ensure the **every area of the country has a suicide bereavement support service for families**, and staff working in mental health services

Progress to date

Every single area now has fully funded plans for adult community crisis services…
- Every single area in England will have a 24/7 mental health crisis and home treatment service which is 'open-access' by 2021
- Long standing restrictions on older adults will be removed
- Every area has ringfenced funding to invest in alternative models of crisis support, such as crisis cafes, safe havens, and crisis houses, providing an alternative to A&E or psychiatric admission.
- By 2023/24, anyone seeking urgent mental health support in England will be able to do so via the simple universal 3-digit 111 number.
- The NHS.UK page will be enhanced so that by 2021, anyone will be able to find contact details of local mental health crisis services through a postcode search on the NHS.UK website

Liaison Mental Health
- Every general acute hospital with a consultant-led 24 hr A&E dept has a liaison mental health service
- 67% of liaison MH services are 24/7hrs and 33% are core 24 compliant (compared with 10% in 2016)
- An extra 471 qualified MH professionals working in liaison services

Out of area placements
- At a national level we have not seen a reduction in OAPs activity over the year, although this hides huge local variation.
- At a national level we have not seen a reduction in activity over the last year. It has remained relatively stable, however, the national view hides significant variation and some improvements at a local level.
- We have seen increasing polarisation in performance between areas, and for the last 6 months, a small minority of the most challenged areas have been responsible for the majority of the OAPs activity.

Number of Inappropriate OAP bed days by provider (rolling quarter to June-19)
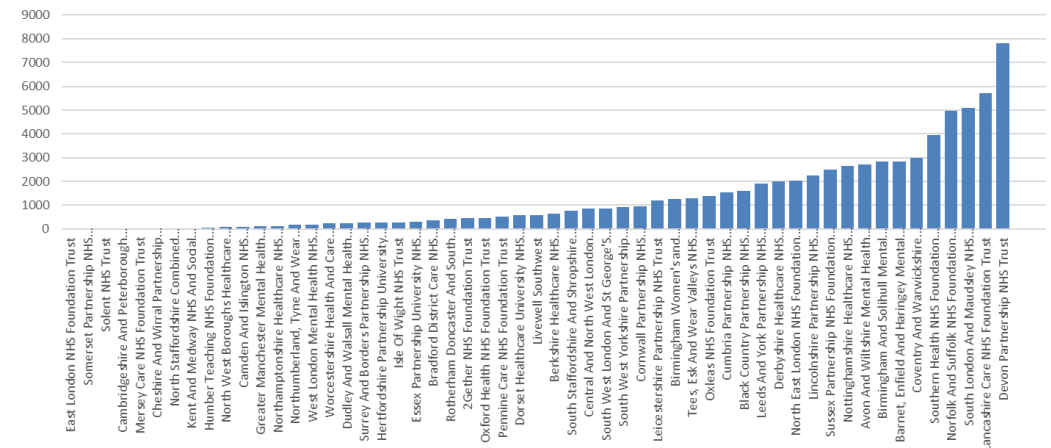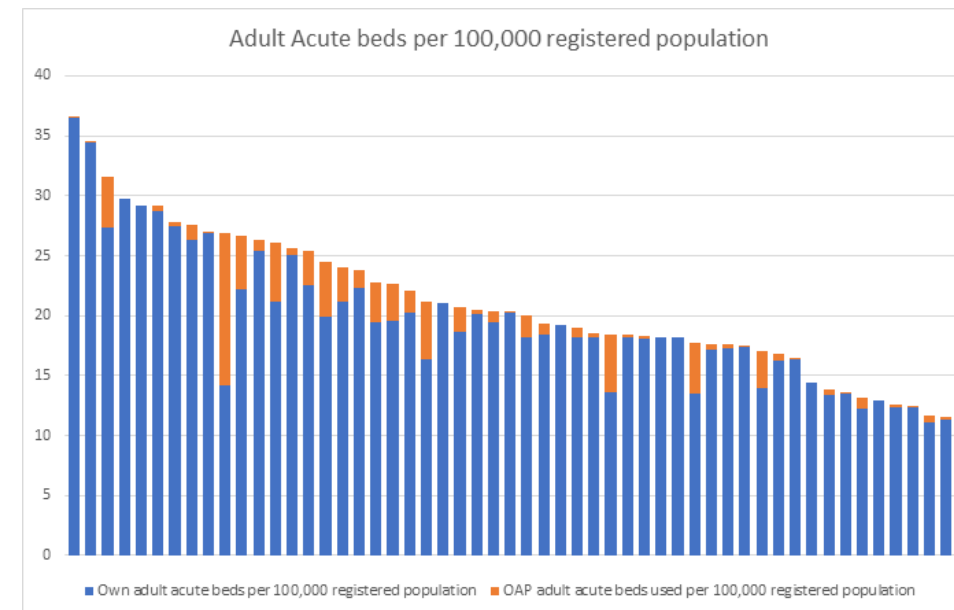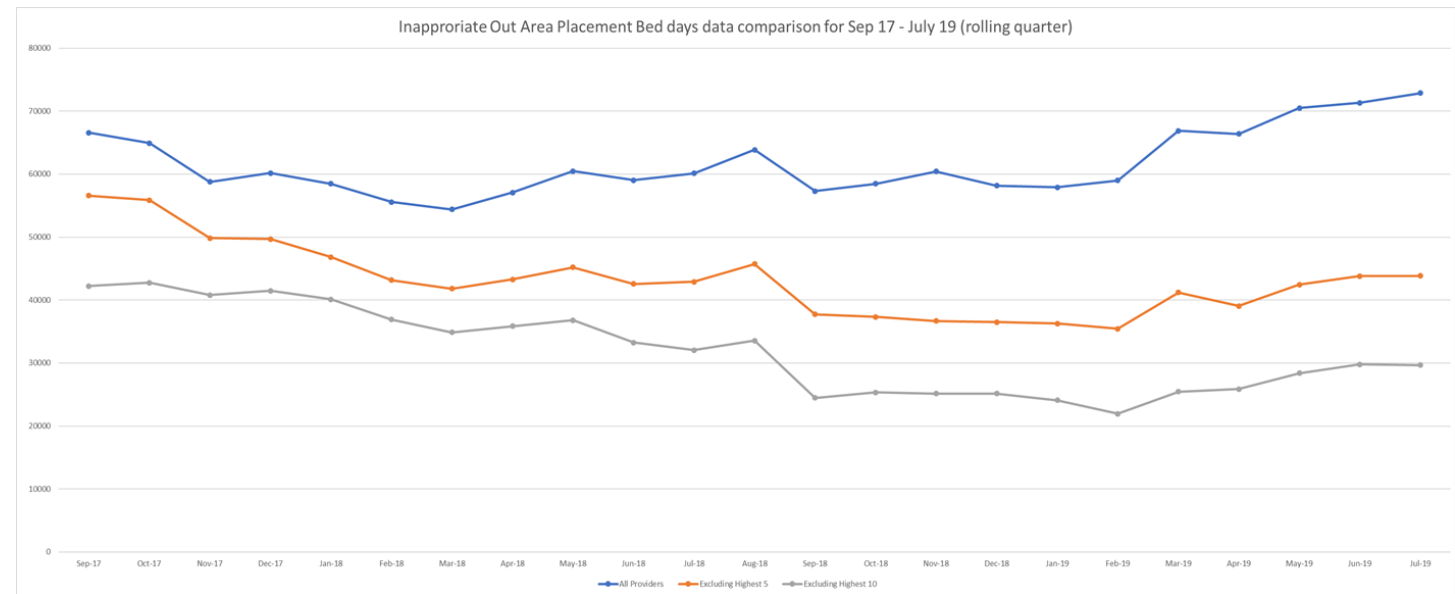
Adult acute out of area placements: trends

Reflections from our national clinical leads:

- The dialogue has dramatically changed in 2 yrs: In 2017 acute out of area MH bed use was seen as inevitable unless bed numbers locally were increased. It is now widely recognised that **OAPs are an indicator of whole a system under pressure and require system-wide solutions.**

- **Variance is not explained by some areas having fewer local acute beds than others**. If admission becomes the default due to lack of community services then no amount of beds even very large local bed bases will not suffice to meet demand.

- There has been widespread agreement with **key principles of bed flow** and that specific focus is needed on the three main phases (admission, care received and discharge).

- In particular, there is now lots of work going on looking at the **broader pathway and community services** to sustainably manage capacity and demand across the system.

Inappropriate Out Area Placement Bed days data comparison for Sep 17 - July 19 (rolling quarter)

Adult Acute beds per 100,000 registered population

5

Further context to the LTP commitment to improve therapeutic inpatient care

- **Clear message from the sector that improvements are needed** – the FYFVMH and much of the LTP focuses on strengthening provision in the community so that people are less likely to need hospital care. However, it's become clear that the lack of policy attention on acute inpatient settings has resulted in less focus on investment and improvements to inpatient care locally.

- **Patient experience** – too many people do not have a positive experience when admitted to hospital. Ensuring care is compassionate and therapeutic is critical in helping people to recover when they are at their most unwell and critical

- **A need to address unwarranted variation in length of hospital stay** – there is significant local variation in the amount of time people spend in hospital, which cannot always be explained by clinical need.

- Building on the local work and learning from **reducing acute out of area placements** – the importance of purposeful admissions and organisational culture has been highlighted in the work to date to reduce OAPs. It has become clear that admissions sometimes occur without clear treatment plans or can become a default option when there is no community alternative available. Addressing this is critical if we are to enable sustainable local capacity management beyond 2020/21.

Therapeutic Acute Mental Health Inpatient Care

NHS

> **LTP wording**: *"For people admitted to an acute mental health unit, a **therapeutic environment** provides the best opportunity for recovery. **Purposeful, patient-orientated and recovery-focused care is the goal from the outset** […] We will work with those units with a long length of stay and **look to bring the typical length of stay in these units to the national average of 32 days**. "*

This has been much more clearly interpreted in the Mental Health Implementation Plan:

Key deliverable:
By 2023/24, *the therapeutic offer from inpatient mental health services will be improved by increasing investment in interventions and activities,* resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings.

How will the therapeutic offer be improved?
- By increasing access to multi-disciplinary staff groups such as peer support workers, psychologists, occupational therapists and other Allied Healthcare Professionals throughout an inpatient admission. It is expected that this will have a direct impact on both the effectiveness and experience of care.
- New baseline investment will be available from 2020/21 to support local workforce expansion and improvements to the therapeutic offer.

National funding and indicative workforce profiles

National Funding profile (M)	2019/20	2020/21	2021/22	2022/23	2023/24
CCG baselines	£0M	£8M	£13M	£26M	£46M

Therapeutic Acute Mental Health Inpatient Care	Year 1	Year 2	Year 3	Year 4	Year 5
Staff group	2019/20	2020/21	2021/22	2022/23	2023/24
Psychologist	0	20	50	90	160
Occupational Therapists	0	20	40	90	150
Support to clinical staff / other therapists	0	70	130	270	450
Total	0	110	230	450	760

- The profiles set out above were modelled on some examples of Trusts with strong therapeutic offers and average length of stay below the current national average.

- Looking at their staff complements in terms of overall numbers and mix, we found that they were above average in terms of:
  - Overall number of staff per acute inpatient bed
  - number of peers support and AHPs (particularly OTs and psychologists) per acute inpatient bed

- The workforce profile is indicative and exactly how the funding is used should be determined through local review and identification of service gaps. However, it must be used to improve the care provided in inpatient settings.

It's not all about the staffing numbers

- While the national funding profile was focused on expanding workforce, we know that staffing number alone will not deliver the improvements in the experience and effectiveness of inpatient care that want to see.

- With the easily measurable elements of the commitment being length of stay and increases in investment and workforce, we risk not addressing some of the broader cultural issues which have such a big impact on the therapeutic nature of hospital care.

Key Lines of Enquiry

To support STPs in the development of their high level 5yr plan for delivering the commitment:

1. Are staffing levels on acute inpatient wards high enough to provide safe and purposeful care at all times? If not, what plans are in place to address this?

2. Do inpatient wards have access to adequate multi-disciplinary/therapy staff (i.e. Occupational therapists, Psychologists and other AHPs as required)? Are peer support workers available to support people?

3. Does the local MH Trust have an understanding of the capacity challenges across its acute mental health pathway and the contributing factors? E.g. interface with community provision / transition / ensuring purposeful hospital stays etc?

4. In addition to addressing any gaps in inpatient staffing, are there other plans in place to improve therapeutic care in acute inpatient wards? (e.g. Do people have access to engaging activities whilst in acute inpatient settings?)

5. Does the local MH Trust regularly monitor adult acute LoS and have plans in place to bring the average time in hospital in line with the current national average mental health settings to 32 days (or fewer) by 2023/24?

In 2021/22, systems will refresh their plans and, **where their average length of stay exceeds the national average, they will be expected to include more detailed trajectories to reduce their averages by 2023/24**. The exact staffing model will be flexible based on the needs of the specific populations.

Implementation support 1/2

- We are currently scoping an implementation support programme to help areas plan investment and improvement in inpatient mental health services over the next four years.
- With a small expert reference group, we plan to consider the following areas for further focus:
  - Therapeutic staffing levels and mix (including non-medical and peer support)
  - Purposeful admissions – including reducing unwarranted time in hospital
  - Safe and effective discharge, including follow up
  - Improving the environment (beyond significant estates developments)
  - Supporting young adults and older people in adult acute inpatient settings
  - Measuring patient experience and outcomes
  - Sexual safety
  - Trauma informed care

Do these areas feel like the right issues too be looking at?

Implementation support (2/2)

Once we've agree areas for focus what kind of activities/resources do you think would help you prioritise and improve care locally?

- Highlighting/promoting existing materials i.e. AIMS standards / Red2Green / Star Wards

- Developing best practice examples / case studies e.g. staffing models / inpatient activities

- Developing an online network for peer learning

- Quality Improvement Collaborative – learning from the success of the Restraint and Restrictive Practice collaborative

- Support with data analysis to drive change locally

- Developing key principles e.g. around purposeful admissions

- Setting up an expert-led support offer to lead bespoke workshops with providers (this has worked well in other policy areas)

Star Wards

Principles of bed flow in mental health services

Maximum investment in the community and making best use of community based assets to **reduce need for acute care**

If tertiary inpatient treatment is required, this should be the **best bed for needs, least restrictive, closest to home. Active care co-ordination** should ensure discharge at the earliest opportunity

If in crisis, wherever possible CRHTT to support person's needs at home- **ADMISSION IS NOT NEUTRAL**.

Release investment from reduced inpatient use and out of area placement to reinvest in communities

Person centred care

People at higher risk of getting stranded need early identification to take account of complex needs and put an appropriate package of care together.

If acute inpatient treatment is required- admission should have clear purpose, expected duration and **PEOPLE SHOULD NOT BE TURNED AWAY**

In inpatient acute **everyday should be effective** in moving towards discharge- **CRHT should lead on discharge where a** person's needs could be met by them at home.

Human factors

BED FLOW

Related ambitions and initiatives

1. Eliminate **out of area placements** for adult acute care

2. The recommendations of the **Mental Health Act Review,** White Paper and Bill *(subject to future Government steer)*

3. **Capital funding to improve the mental health estate** *(subject to future capital funding settlement)* including inpatient wards, places of safety, crisis cafes, houses, A&E assessment spaces, ambulance vehicles

4. Existing **Quality Improvement** Collaboratives address use of **Restraint and Restrictive practice and improving Sexual Safety** in inpatient settings

5. A **2019/20 CQUIN** to encourage **follow-up within 72 hours of discharge**

The LTP ambition on improving acute inpatient care interfaces with a huge range of ongoing and future work. We need to make sure we focus on the most impactful things and use national resource in the most helpful way.

Questions for discussion

- Which of the challenges discussed feel most relevant?
- What work is currently going on locally in this space?
- Do the areas identified for further focus and support feel right?
- How could we work more closely with AIMS?
- What sort of support to colleagues think will add most value?

Any other questions?