Preparing to implement mental health access and waiting time standards

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1. Context

2. The standards to be introduced from 15/16
   - Early intervention in psychosis
   - Psychological therapies
   - Liaison mental health

3. Other access work
   - Perinatal mental health
   - Eating disorders (CYP)
MH 5YP: rebalancing the system

- Prevention
- Early intervention
- Effective care
- Recovery

- Right care
- Right time
- Right setting

1. Local community – education, employers, leisure providers
2. Primary care
3. Mental health assessment services
4. Community-based mental health services with integrated social care and supported housing
5. MH acute and crisis services
6. MH rehabilitation (complex needs)
7. T4 MH services

- Positive mental health: prevention, resilience-building, self-assessment & management, e-mental health
- Recognition of mental-ill health and appropriate onwards referral
- Timely and expert assessment and assignment to treatment pathway
- Evidence based, personalised care in primary care & community settings.
- Safe and effective 24/7 acute and crisis care (inpatient / A&E / home treatment)
- Recovery focused inpatient rehab services with linked community teams
- High cost, specialist inpatient care with linked community teams
The system is currently not in balance

- **a. Inadequate capacity to deliver effective upstream interventions at levels 1-4**
- **b. Pressure at the higher tiers of service provision**
- **c. Inadequate pathways out of high cost inpatient care (levels 7, 6 and 5) due to a lack of capacity and effective service models at level 4.**

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- **a + b + c**
  - = inadequate access to effective, evidence-based care and excessive waiting times
  - = mental health conditions becoming ‘long term conditions’ when they need not be
  - = first access to treatment occurring too often at levels 5 & 7 and too often via police / criminal justice system
  - = escalation of demand to the most expensive and restrictive tiers of care
  - = use of expensive out of area placements at levels 5-7
  - = poorer outcomes
Access and waiting times are part of a wider commitment to parity of esteem for mental health...

Equivalent standards as for physical health:
- **Tackle long waits for treatment**: ensure that access to service is timely
- **Reduce the treatment gap**: increase the number of people accessing treatment
- **Embed NICE-concordant care in all areas**: ensure that services accessed are evidence-based, clinically effective, safe and recovery focussed
...and align closely with the clinical strategy of our National Clinical Directors

Bio-psycho-social approach, with whole-person care encompassing:
- Psychological therapies and safe medication
- Physical health
- Crisis prevention and management
- Wider determinants: relationships/parenting, housing, employment etc

Focus **across the entire life-course**:
- Being born well, and best early years development
- Living, working and growing older well
- Dying well

Supporting effective **action through Clinical Networks**:
- Provide leadership on Business Plan priorities: CAMHS, ED, Perinatal, EIP
- Embed mental health within all areas of work: (eg) stillbirth/neonatal death, reducing child mortality, transition from paediatric to adult services for LTCs

**Demonstrating value**:
- Focussing on outcomes (and savings to the public purse) of effective care
- Robust evaluation and timely data to drive continuous improvement
- Using public and political awareness to show tangible benefits

Dr Geraldine Strathdee
Mental Health

Dr Jackie Cornish
Children, Young People and Transition
Access and waiting time standards in mental health build on existing standards elsewhere in the NHS

**Waiting-time standards**
*Maximum time people should wait*

- Build on “Big 5” standards operating elsewhere in the NHS, currently covering:
  - A&E (4 hour to admission, discharge or referral)
  - Cancer (2 weeks to specialist appointment, 2 months to treatment)
  - Elective care (18 weeks referral-to-treatment)
  - Diagnostics (6 weeks)
  - Ambulance (8 or 19 minutes)
- Set out in the NHS Constitution and Government’s Mandate to NHS England
- Data published weekly/monthly/quarterly

**Access Standards**
*What services, and who should access them*

**Service level**
*What service people will access*
- Could cover:
  - Availability of service in all areas
  - Workforce training and staffing levels
  - Delivery of NICE-approved interventions
  - Routine outcome measurement
  - Method of access (eg single point)
  - Patient choice (where appropriate)

**Patient level**
*How many people access treatment*
- Could include:
  - A given number of people
  - Equitable access across patient groups
Two initial sets of standards – first stage of a five-year plan

1. Better Access by 2020
   October 2014

   Early Intervention in Psychosis
   - 50% of people experiencing a first episode of psychosis treated with a NICE-approved package of care within two weeks of referral
   - £40m recurrent funding

   Psychological therapies (adults)
   - 75% treated within 6 weeks, and 95% within 18 weeks
   - £10m non-recurrent funding

   Liaison mental health
   - Support effective models of liaison psychiatry in a greater number of acute hospitals
   - £30m non-recurrent funding

2a. Autumn Statement
   December 2014

   Eating Disorders – children & young people
   - Improve CYP access to dedicated, evidence-based community services
   - £30m recurrent funding

2b. Budget
   March 2015

   Perinatal
   - Process underway to inform allocation and implementation
   - £15m recurrent funding for five years

3. The Mental Health Task Force, chaired by Paul Farmer (Mind), is producing a five-year plan for the NHS to improve mental health services. This may include further standards.
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<td>3. Publication of commissioning guidance</td>
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<td>4. Design of levers &amp; incentives</td>
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<td>5. Implementation support</td>
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<td>6. Workforce development</td>
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2. The new standards to be introduced from 2015/16
Expectations of commissioners

- Planning guidance requirement that service development and improvement plans (SDIPs) are agreed setting out how commissioners and providers will prepare for and implement the new standards for EIP and psychological therapies in 15/16 and achieve them on an ongoing basis from 1 April 2016.

- Commissioners should agree SDIPs with acute providers, setting out how providers will work to ensure there are adequate and effective levels of liaison MH services across acute settings.

- Clear expectation that the additional £40m funding for EIP being made available recurrently should be invested recurrently in EIP services.

- Local agreement on pricing so increases should take into account baseline performance against both elements of the EIP standard.
Early intervention in psychosis (EIP)

- The new access and waiting time standard requires that, by 1 April 2016, more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.

- The standard is ‘two-pronged’ and both conditions must be met for the standard to be deemed to have been achieved, i.e.
  - A maximum wait of two weeks from referral to treatment; and
  - Treatment delivered in accordance with NICE guidelines for psychosis and schizophrenia - either in children and young people [CG155 (2013)] or in adults [CG178 (2014)].

- Most initial episodes of psychosis occur between early adolescence and age 25 but the standard applies to people of all ages in line with NICE guidance.

- Both elements of the standard will be measured – the wait from referral to treatment and whether the treatment accessed is NICE concordant.
Where are we now?

**Expert advice and input**
*Convened by NCCMH*

- **Expert reference group** established who have:
  - Designed the RTT pathway
  - Specified the interventions that need to be captured
  - Specified the outcomes dataset

**Dataset development**
*Led by HSCIC*

- Worked with HSCIC and provider information experts to agree changes required to MHLDDS and timeframe for delivery.
- Changes to data systems and new dataset should take effect from **1 January 2016**.

**Regional leadership and implementation work**

- Four regional preparedness programmes established.
- Undertaken workforce surveys to provide more granular detail on skill mix and competencies.
- Raising awareness of standard
- Tools for self-assessment developed / in development.

**National tools to support implementation**

- Working with NCCMH and technical team of experts to develop a **commissioning guide** to support local commissioning and planning.
- HQIP has commissioned a **national clinical audit** of EIP services to understand the current level of NICE concordance – report in April 2016.
- Working with RCPsych (CCQI) to establish an **accreditation scheme** for EIP services.
Regional preparedness work

1. **Raising awareness** – What are the requirements of the new standard? What are the implications? What are the opportunities?

2. **Bringing together the experts and establishing quality improvement networks**

3. **Understanding demand** – incidence, incidence profiles etc

4. **Understanding the baseline position + gap analysis** – staffing, skill-mix, competency to deliver full range of NICE concordant interventions

5. **Optimising RTT pathways** – need to engage all of the potential referral sources, many of which will be **internal** within secondary care

6. **Preparing for the new data collection requirements** – training for service and information leads

7. **Developing the workforce – capacity, skills & leadership** – can the workforce deliver the full range of NICE concordant interventions as this will be the definition of ‘treatment’?
Psychological therapies (adults)

- New standard requires that 75% of adults with common mental health conditions referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral.

- Also maintaining standards of ensuring that at least 15% of adults with relevant disorders have timely access to psychological therapy services with 50% recovery rate.

- £10m investment focuses on:
  - Achieve fully validated waiting lists and good operational processes in all IAPT services by the end of Q2 (£2m)
  - Clear backlogs in services where there are long waits for first treatment, post first treatment and at step up (£6m)
  - Support a central programme of transformation to support the implementation of these standards (£2m).

- In addition, national support continues to be available for recovery work:
  - Leadership and training events accompanied by re-launch of “Enhanced Recovery High Impact Changes” (July-Sept)
  - Create greater granularity on recovery and reliable improvement rates by step, modality and diagnostic coding in NHS England report/risk list and for use with providers (Oct)
  - Establish consensus on factors that limit potential for recover (e.g. deprivation) (Oct).
Liaison mental health and crisis care

• By 2020, all acute trusts will have in place liaison psychiatry services for all ages appropriate to the size, acuity and specialty of the hospital. In 2015/16 we are investing £30 million to enable a greater number of acute hospitals to establish effective models of liaison psychiatry.

Where are we now?
1. From 2015/16, when the Care Quality Commission (CQC) rates acute services, it will include a specific focus on liaison mental health services.
2. Investment of the £30m has been confirmed. This breaks down as:
   • £25m investment on liaison mental health in A&E departments
   • £1m (£250k x 4) for NHS regions for preparedness for a future standard on liaison mental health (to buy clinical expert advice and programme management resource)
   • £4m for the eight urgent and emergency care vanguards to test and evaluate models of all-age liaison mental health, data systems and development of new payment models.
3. We are establishing a crisis care programme using the same methodology as the rest of the access and waits standards. Our hope is to introduce access and wait standards for crisis care, along with necessary infrastructure (dataset development, audit, commissioning guidance, quality improvement, levers and incentives, workforce development, etc.)
3. Other work on improving access
Perinatal mental health

The National Collaborating Centre for Mental Health are leading a process of expert engagement.

**Expert advice and input**

*Convened by NCCMH*

**Broad definition of expertise required:**
- Clinical (all appropriate specialties)
- Non-clinical professionals
- Experts by experience
- Commissioners
- Service managers

**Remit to advise NHSE on:**
- How best to commission NICE-concordant care
- Possibility for access/waiting-time standards
- Use of additional funds
- Wider enablers and success factors (workforce, datasets, payment/levers etc)

**Work to produce:**
- Model pathways
- Commissioning guidance

**Expert Reference Group**

*Have met twice: June, July, and further meeting in September*

- Facilitator: Prof Steve Pilling (UCL, NCCMH)
- Chair: Dr Lise Hertel (Newham CCG)
- Cross-disciplinary expertise:
  - By experience
  - Mental Health: Commissioning, Psychology, Psychiatry
  - Others: Health Visiting, Midwifery, Obstetrics, Pharmacy

**Technical Team**

*Meets fortnightly*

- Cross-disciplinary expertise: Commissioner, Psychiatrist, Service Adviser
- Supported by: Editor, Facilitator, Health Economist, NHS England programme staff, Project Manager, Research Assistant
Eating Disorders (CYP)

**NCCMH Expert Reference Group developed:**
- Access and waiting time standard
- Referral to treatment pathways
- Model for delivery of dedicated community eating disorder services for children and young people (CEDS-CYP).
- **Commissioning guide with workforce calculator** has been published to support local commissioners with transformation.

http://www.england.nhs.uk/resources/resources-for-ccgs/#local-trans

**Access and waiting time standard**
- Those referred for assessment or treatment for an eating disorder should receive NICE concordant treatment within one week for urgent cases and within 4 weeks for every other case.
- Introduced and monitored in 2015-16 via MHSDS; **tolerance levels to be set and standard implemented from 2017-18**

**Quality improvement and accreditation network**
- Quality Network for CEDS-CYP linked to QNCC and will be available from April 2016

**Education**
- Eating disorder curricula group being convened in partnership with HEE (first meeting October 2015)

**Submission of plans: CYP** Transformation Plans need to demonstrate how monies for eating disorders are used to enhance or develop CEDS-CYP or, where CEDS-CYP are in place how any underspend or release in capacity will be used to benefit those who self harm or are in crisis.
A few final reflections

• The way we measure and implement standards are critical – it can’t ‘just’ be a waiting time standard. It must also be about the quality of care that people access after the clock stops.

• A key principle we hope to take into any future standard work is to focus on:
  ➢ A clinically informed maximum waiting time (RTT)
  ➢ For access to NICE-concordant care
  ➢ With routine measurement of outcomes.

• We hope this approach has the potential to support transformed care, improve outcomes and have a significant impact on ‘rebalancing’ the system – with a real impact on people who are in need of mental health support.

• There is, and continues to be, a lot to do – collaboration is essential and we welcome it!
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