5. Adult mental health: community, acute and crisis care

2020/21 Objectives

By 2020/21, adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors. This will deliver:

- At least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral.
- A reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
- A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
- Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

By 2020/21, community mental health services for adults of all ages will be better supported to balance demand and capacity, deliver timely access to evidence-based interventions, integrate with primary care, social care and other local services, and contribute to the delivery of efficiencies across the adult mental health system. Only by doing this can services begin to meet the challenge of closing the treatment gap to improve outcomes and reduce suffering for people with more severe mental health needs.

Within this overarching ambition sit four specific objectives which focus on particular cohorts or outcomes. For people aged 14-65 experiencing first episode psychosis, this will ensure that the full range of NICE-recommended interventions are available in all areas, and improve timely access from the current target in the 2016/17 Planning Guidance. Objectives relating to individual placement and support, psychological therapies and physical health will focus on adults who are in contact or have had sustained contact with secondary mental health services.

The table below outlines an indicative trajectory for delivery of these objectives:

Objective		2016/17	2017/18	2018/19	2019/20	2020/21
Early intervention in psychosis	% of people receiving treatment in 2 weeks	50%	50%	53%	56%	60%
	Specialist EIP provision in line with NICE recommendations[xi]	All services complete baseline self-assessment	All services graded at level 2 by year end	25% of services graded at least level 3 by year end	50% of services graded at least level 3 by year end	60% of services graded at least level 3 by year end
People with a severe mental illness receiving a full annual physical health check			140,000	280,000	280,000	280,000
Doubling the number of people accessing individual placement and support		Baseline audit of IPS provision undertaken	STP areas selected for targeted funding	25% increase in access to IPS	60% increase in access to IPS	100% increase in access to IPS

By 2020/21, all areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.

Out of area placements will essentially be eliminated for acute mental health care for adults.

The Independent Commission on Acute Adult Psychiatric Care painted a picture of an acute mental health system under pressure, with difficulties in access to care compounded by – in some instances – poor quality of care, inadequate staffing and low morale. Too often, inadequate data and information are available to support improvement.

The majority of CRHTTs are not currently sufficiently resourced to operate 24/7, with caseloads above levels that allow teams to fulfil their core functions of a community-based crisis response and intensive home treatment as an alternative to admission. By 2020/21, CRHTTs in all areas should be delivering in line with best practice standards as described in the CORE fidelity criteria . To support the required expansion over this period, all areas should review their current provision during 2016/17 against CORE standards and develop plans to ensure full compliance.

Delivering the expansion of CRHTTs is critical both to alleviate the suffering of individuals in crisis, but also to alleviate pressure on acute in-patient mental health care and tackle inappropriate and expensive acute out of area placements. Inappropriate out of area treatments (OATs) for acute mental health care should be eliminated in all areas by 2020/21.

As a first step towards eliminating OATs nationally, the Department of Health, NHS England, NHS Improvement and NHS Digital have been working with stakeholders to agree a first national definition of OATs alongside a new national data collection that will enable accurate measurement and analysis, including placement type, reason, duration and cost. In 2016/17, all localities should put in place plans to ensure robust monitoring of OATs for all bed types, with the aim of delivering a demonstrable reduction in acute OATs by March 2017.

By 2020/21, all acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum.

The financial and clinical evidence for liaison mental health services for adults is clear, yet not every acute hospital is equipped with expert staff who are able to assess and care for people with mental ill health skilfully and compassionately whilst supporting and training other hospital staff to do the same. By 2020/21 all acute hospitals will have liaison teams in place in emergency departments and in-patient wards, with at least half providing this on a 24/7 basis in line with the 'Core 24' standard.

The table below outlines an indicative trajectory for the proportion of acute hospitals achieving the Core 24 standard over the period:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
% acute hospitals with an all-age MH liaison service achieving Core 24 service standard	7% (current)	13%	20%	40%	50%

During 2016/17, STPs should develop their approach to liaison mental health to achieve buy-in across the organisations which will commission, provide and partner with those services, and ensure that savings are identifiable in order to be reinvested. This will include consideration of the acute hospitals in the STP footprint that can serve as 'centres of excellence': those already meeting or exceeding the minimum Core 24 standard and those closest to meeting it that can support the development of liaison mental health services across the wider area.

The Core 24 service standard is a standard for adult liaison mental health services. For children and young people, the evidence base on models of crisis response is less well developed. As noted in chapter 3, NHS England is therefore targeting funding during 2016/17 to evaluate models of crisis care for children and young people to achieve consensus on effective, high-value models of care that can be shared to stimulate further expansion over the next five years.

By 2020/21, all NHS-commissioned mental health providers will have armed forces champions and a specific named clinician with an expertise in military trauma.

There will be a network of specialist collaborative providers that have been co-commissioned with CCGs to provide accessible bespoke care for the armed forces community. This will include accessible services for complex post-traumatic stress disorder and other complex presentations that are bespoke for the armed forces community.

The mental health needs of the armed forces (AF) community are subtly different from those of the general population (in terms of complexity), although the overall incidence is not significantly different from other population groups. This includes the presence within the AF community of certain vulnerable groups (including young men and women in the army, the combat arms, reservists and families). However, commissioning arrangements for this community are complex and are split between the Ministry of Defence (for the routine primary, community and secondary care of serving and mobilised reservists) and CCGs (for non-mobilised reservists, veterans and service families, and all crisis care).

Research will be conducted to demonstrate the most effective mental health treatment for the AF community. This will support the development of new services, co-commissioned by CCGs and the MoD, to respond to the particular problems and complex presentations within the AF community, including for post-traumatic stress disorder (PTSD) and substance misuse.

Delivering the objectives: Workforce requirements

Delivering the proposed improvements to adult mental health services will require a consequent expansion in the skills and capacity of the workforce, as well as ensuring collaborative working between mainstream and partner services, such as learning disability and liaison and diversion services, to build the care around the person.

- Early intervention in psychosis (EIP) – Health Education England (HEE) will deliver a programme to ensure there are sufficient numbers of appropriately trained staff to deliver the key interventions recommended by NICE, particularly psychological therapy (cognitive behavioural therapy for psychosis and family intervention) by 2020/21.

- Individual placement and support (IPS) – employment specialists within IPS services are highly skilled non-clinical staff and require a range of qualities and competencies. NHS England will work with HEE and with IPS specialists to develop a competency framework and workforce development strategy to support the planned expansion.

- Physical health checks – additional investment will be deployed to ensure that primary care staff feel confident in actively supporting people with severe mental illness to access relevant physical health screenings and interventions. For example, in a recent survey, 42% of practice nurses reported that they had received no mental health training

at all. The new investment will ensure mental health training and support for staff working in primary care.

- Improving access to psychological therapies for people with psychosis, bipolar disorder and personality disorder – the IAPT-SMI sites have demonstrated the positive impact of access to NICE-recommended psychological interventions on experience, outcomes and reduced healthcare utilisation. NHS England and Health Education England will work to build on the IAPT-SMI programme and 'scale up' so that a greater number of people have access to psychological therapy as a core component of the adult mental health services offer.

- Mental health liaison – to deliver the objective for adult mental health liaison, the existing workforce capacity will need to increase. The workforce requirement for the Core 24 standard was set out in guidance published by the South West Strategic Clinical Network[XIII] and further central guidance will be published later in 2016/17.

Delivering the objectives: Investment and savings

The table below breaks down the additional investment required in the areas outlined to support delivery of the objectives above:

Funding type	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
CCG baseline allocations					
Crisis and acute care		43.0	90.0	140.0	146.0
Early intervention in psychosis		11.0	20.0	30.0	70.0
Physical health interventions		41.0	83.0	83.0	83.0
STF monies for allocation (indicative)					
Mental health liaison services		15.0	30.0	84.0	120.0
National programmes (indicative)					
Community mental health			13.0	33.0	50.0
Crisis: places of safety (capital)	9.0	6.0			
Armed forces	1.68	1.68	1.68		

Key

Local Funding
National Funding

For **crisis and acute care**, the majority of costs will be for new staff in crisis resolution and home treatment teams (CRHTTs) to ensure that effective service models can be properly resourced. A typical CRHTT per 150,000 population would carry a home treatment caseload of 20-30 people, and would comprise a consultant psychiatrist, mental health nurses, approved mental health professionals, occupational therapists, psychologists and support or peer workers.

Funding for crisis care will be supplemented by £15 million of additional capital investment over 2016/17 and 2017/18 to improve health-based places of safety, and will be subject to a bidding process.

For **mental health liaison**, the majority of new investment will fund growth in workforce capacity. A typical 'Core 24' liaison mental health team covering a 500-bedded acute hospital comprises c25 WTE: a mixture of liaison psychiatrists, mental health nurses, therapists and administrative staff[VIII]. Innovative services also include dedicated social work input, such as the liaison service in Bradford, and input from specialist substance misuse clinicians, for example the service in Nottingham, which have also been demonstrated to deliver significant benefits.

Transformation funding for mental health liaison will be made available from 2017/18. During summer 2016 NHS England will work with stakeholders, including the Royal College of Psychiatrists' Liaison Faculty, to model and analyse different options for funding allocation. This will take into account the findings of the third annual survey of the liaison psychiatry workforce (due to report in August). Further detail on the proposed allocation method will be made available in October 2016.

Additional funding for **early intervention in psychosis** estimates the costs for an additional 10% of people to be treated within two weeks as £70 million per annum when fully implemented including costs of workforce development. The profile builds up this steady state over four years from 2017/18, in order to achieve a deliverable phasing of improvement and additional capacity. This funding does not include the baseline monies provided from 2015/16, which are recurrent at £40 million per year over this period.

Funding to deliver **physical health checks for people with severe mental illness** (SMI) will enable CCGs to offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year. The costs (relating to the additional training and capacity needed for the workforce to deliver checks) are based on a pilot enhanced service offered in North East London, the results of which are soon to be published. Development work is ongoing, with the intention to publish further detail on proposed delivery models for this objective by December 2016.

Central programme funding for community mental health services will include amounts to develop a programme to scale up delivery of Individual Placement and Support to reach double the number of people with severe mental illness, and increase the reach of psychological therapies building on evidence from the IAPT for SMI demonstrator sites. This is expected to be targeted and will deliver some savings to both the NHS and Exchequer.

For mental health care in the **armed forces community**, baseline funding from 2016/17 should support specialist in-patient services for PTSD and investment in new online support and regional services. Central funding identified will support co-commissioning work with CCGs for the national procurement of local specialist community services, and investment in research to improve the evidence base on effective interventions for the armed forces community.

As outlined, substantial **savings** are expected to be realised from investment in crisis and acute mental health, EIP services and improved physical health care for people with severe mental illness. The table below sets out the expected savings to be released based on the investment specified above:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
Expected savings: crisis and acute mental health care			-64.0	-135.0	-168.0
Expected savings: early intervention in psychosis		-4.0	-8.0	-12.0	-20.0
Expected savings: physical health care for people with SMI		-27.0	-81.0	-108.0	-108.0
Expected savings: mental health liaison services			-15.0	-30.0	-84.0

In relation to crisis care, the expanded CRHTTs will make a critical contribution to managing the pressures on acute in-patient beds that lead to increased bed occupancy and, ultimately, to people being sent out of area. The acute care pathway (see chapter 12) that will be developed during 2016/17 will incorporate demand and capacity management and will use learning from areas such as North East London, Bradford and Sheffield where the acute care pathway has been redesigned so as to completely eliminate OATs. There is good evidence that once CRHTTs are fully funded and operating effectively, CCGs will be able to cash savings from reduced mental health in-patient activity through elimination of spend on acute out of area placements and bed reductions[XIV].

Expected savings for early intervention in psychosis achieved over this period are based on analysis conducted by the Centre for Mental Health/London School of Economics/Rethink which estimated the savings per person from decreased use of acute mental health services[XV]. Further wider benefits are realised due to improved employment and education outcomes and longer-term reduced risk of suicide.

Savings in relation to physical health screening and interventions for people with severe mental illness are derived from a 2015 QualityWatch report[XVI]. This report demonstrates that in 2013/14, people with severe mental illness had almost seven times more emergency in-patient admissions, and three times the rate of A&E attendances, of which half this activity

was unrelated to mental health need and was instead driven by urgent physical health care needs. Modelling based on the report has identified cash-releasing and capacity-releasing efficiencies from reduced A&E attendances and non-elective admissions realised through improved access to physical health screening and interventions in line with NICE recommendations.

Mental health liaison services are expected to become self-sustaining within 12 months once savings are reinvested, based on a conservative interpretation of the savings predicted by the RAID evaluation (£4 for every £1 invested)[XVII]. These savings are, in the main, capacity-releasing and are derived from reduced acute hospital activity, including reduced admissions and length of stay (particularly for older adults with dementia) and reduced re-attendance.

Delivering the objectives: Data, payment and other system levers

The CCG Improvement and Assessment Framework includes indicators for tracking performance in EIP, out of area treatments and crisis care. It is expected that these 'transformation indicators' will be replaced with data from the Mental Health Services Data Set (MHSDS) in the future.

The new MHSDS enables the routine capture and reporting of information regarding referral to response, assessment and treatment times, interventions delivered (and whether in line with NICE recommendations) and outcomes (clinician and patient reported). There remains significant work required to improve the completeness and quality of data submitted and this will be a key area of focus for NHS Digital, NHS Improvement and NHS England. Other data collections will provide service-level data such as workforce, caseloads and hours of operation.

NHS England will also work with HEE and other partners to undertake an audit of employment services in secondary mental health services. The audit will investigate fidelity to the IPS model and highlight workforce, outcomes and activity of secondary mental health employment services.

Metric	Source	Availability
Crisis care milestones: liaison MH, CRHTTs, places of safety	CCG IAF/Unify	From Q1 2016/17
OATs milestones: monitoring, commissioning plans	CCG IAF/Unify	From Q1 2016/17
Number of non-specialist acute MH OATs	MH SDS	From Q1 2017/18
% of people with first episode psychosis commencing NICE-recommended package of care within two weeks of referral	Unify	Now
% of EIP services meeting full range of NICE standards	CCQI validation of self-assessment	Q4 2016/17
% of acute hospitals with a 24/7 liaison mental health service at minimum Core 24 standard	Annual audit (HEE/ Univ. of Plymouth)	August 2016
CCG spend on: liaison MH in acute hospitals, EIP, CRHTTs	NHSE finance tracker	From Q1 2016/17
Data on access and outcomes for veterans in all mental health services (including IAPT data sets)	IAPT	Now (IAPT) and from Q1 2017/18

The 2016/17 CQUIN on improving physical healthcare to reduce premature mortality in people with severe mental illness is an important lever in addressing the issue of physical health care for this group. It covers in-patient wards, EIP services and community mental health services. NHS England will seek to extend the CQUIN beyond 2016/17, learning lessons about effective delivery and measurement from working with providers and the appointed CQUIN audit partner.