

Mental health and A&E pressures

- 1. Analysis of winter schemes for mental health funded in 17/18*
- 2. Further examples of mental health schemes that help alleviate operational A&E pressures*



Introduction

This briefing aims to share learning about mental health services that support the aims of the urgent and emergency care / winter operations programme. For the purposes of this briefing, we are taking this to mean mental health services that can:

1. reduce avoidable mental health attendances to emergency departments (EDs);
2. support quicker discharge from A&E (i.e. avoid 4hr / 12hr breaches)
3. reduce avoidable emergency admissions to general acute hospitals or mental health hospitals;
4. facilitate earlier discharge from general or mental health hospitals

The case studies in this paper focus mainly on ED/ general hospital pressures. However, mental health system pressures have a direct impact on acute hospital pressures. For instance, it is believed one of the most common reasons for 12-hour admission breaches is inability to find an inpatient mental health bed (due to overall mental health system capacity pressures).

Background: winter 17/18 MH allocations

£18m was allocated for mental health-related schemes with priority given to:

- MH services that support A&E departments with a category 3/4 rating;
- MH services that support A&E departments that have challenges around mental health-related needs demonstrated by e.g. high levels of MH-related A&E breaches (4hr/12hr);
- MH Trusts that have high levels of out-of-area placements (OAPs).

Out of 234 schemes across England funded by the £18m, there were:

- 58 mental health liaison schemes;
- 32 community crisis resolution/home treatment/ 'first response' schemes;
- 28 discharge and step-down schemes (across acute and mental health services);
- 18 specialist children and young people's schemes*;
- 24 older people's mental health/dementia schemes*.

*some of which include specialist liaison mental health services, which aren't counted in the overall liaison figure to avoid double counting.

Further categorisation of schemes with slightly more detail is at **annex A**

Scope and limitations

Data:

- historic design of A&E datasets mean it is not possible to reliably and routinely count the number of A&E mental health attendances;
- this has made it challenging to systematically understand the extent of mental health demand on A&E or to assess impact;
- efforts are underway to address this through the new Emergency Care Data Set

Winter mental health schemes 17/18

- The majority of mental health schemes reported positive qualitative impact, but supplied limited quantitative data (as this was not requested as part of the allocation process);
- This pack contains findings from those areas that voluntarily collected quantitative data;
- Given the timescales of the allocation process, most schemes sought to augment existing services (e.g. by extending hours), with a minority using the funding to pump-prime new schemes;
- Common feedback has been that with more time to plan, services feel they would have been able to achieve even more positive impact

The paper sets out examples of:

- services and schemes implemented quickly to make use of short-notice, short-term winter monies, both in 17/18 and in previous years (e.g. through vanguard programmes and local system resilience funding);
- established urgent and emergency mental health services that support winter pressures (where capacity and hours of operation can be extended during times of highest demand in winter)

MH recommendations for winter: identifying local gaps in capacity



- Set out below are parts of the mental health system where lack of capacity contribute directly to A&E pressures when people are experiencing mental health crisis;
- Steps should also be taken to preventing needs escalating to crisis through provision of community mental health services, social care and reviewing care plans / packages.

1. **Provision of community based mental health crisis services that can reduce / divert mental health attendances to A&E, with clear and open routes of access**

- 24/7 mental health crisis teams
- Open-referral to crisis services including self-referral, public, GPs, police, ambulance, NHS111
- Clear points of access and central management of crisis pathway (as opposed to multiple disparate services)
- Alternatives to A&E, e.g. crisis cafes, sanctuaries, havens to provide crisis/pre-crisis, non-clinical option to prevent escalation to crisis and likely to be more suitable option for many people's need
- Mental health professionals in ambulance, police control centres, NHS111 to improve triage

2. **24/7 access to psych liaison in A&E to enable rapid, safe assessment and discharge from A&E and wards**

- Rapid referral to liaison MH teams for MH presentations to A&E / 1hr response from liaison teams
- Sufficient capacity to provide cover to wards, response within 24hrs to ward referrals, facilitate discharge
- Safe, calm assessment spaces for mental health in or near A&E

3. **Understand & address mental health system pressures that contribute to delays in transfer from A&E**

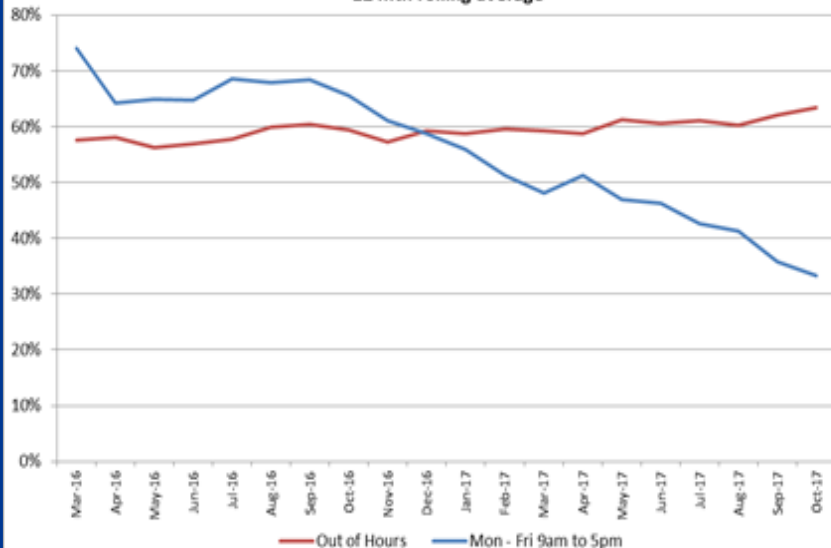
- 24/7 home treatment teams with sufficient capacity to offer intensive HTT and true alternative to admission
- Provision of community alternatives to mental health inpatient admission, e.g. crisis houses
- Purposeful admissions from day 1 supported by discharge planning (including social care and housing needs) early in admission to reduce length of stay. Focus on eliminating 0-3 day stays and 60+ day inpatient admissions likely to free significant bed capacity
- Assessment of staffing / capacity of AMHPs and s.12 doctors to respond to Mental Health Act assessments

Mental health winter funding schemes 17/18

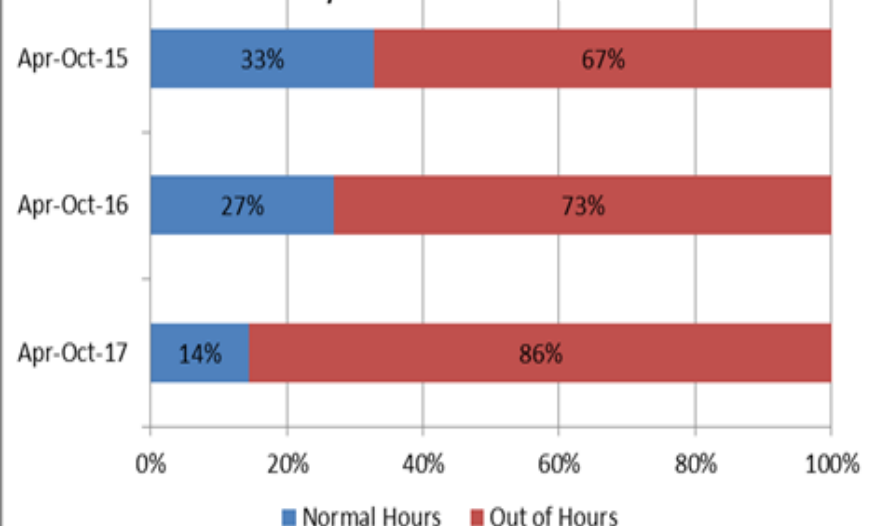
Southampton: CAMHS Psychiatric liaison (£94k)

- CAMHS psychiatric liaison nurse within UHS. Originally from 16/17 winter pressures money that was extended into 17/18 by CCG. Post would have ended if the 17/18 winter pressures money was not available
- Approximately 25-30% of mental health attendances are during the working hours of this post; therefore the post can currently only impact on 30% of admissions.
- Since this post has been in place, there has been a **significant decrease in the % of Southampton ED attendances (children and young people aged 10-17 with mental health issues) admitted during weekdays whilst the % admitted during out of hours has increased slightly – this highlights the post is reducing the number of non-elective admissions.**

UHS Mental Health ED Attendances - % admitted
12 mth rolling average



% of All MH Attendances that are Admitted
by Normal & Out of Hours

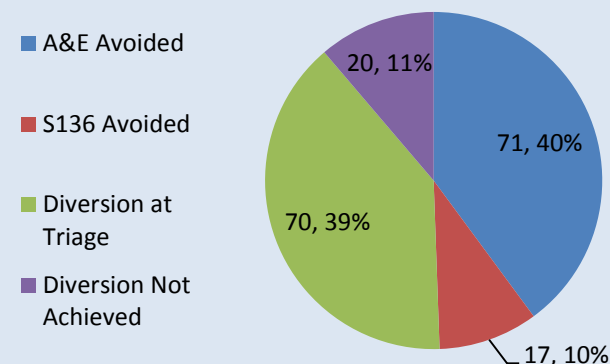


Mental health winter funding schemes 17/18

Southwark: crisis assessment team (£386k)

- Band 7 MH nurse assessors attend and work alongside London Ambulance staff and police officers providing an alternative to conveying patients to A&E or Place of Safety.
- Expansion of the Acute Referral Centre, offering a face to face crisis assessment function.
- 17/18 winter funds enabled mobilisation ahead of schedule, as well as enabling the team to commence assessments from 2pm as opposed to 5pm.

CAT outcomes to date (as at 12.03.18)



Doncaster & Bassetlaw: expansion of older adult psych liaison function in A&E (£94k)

For the period 22.1.18 to 6.2.18, targeted screening of initial patient cohort (over 65s) resulted in 572 patient record screenings within the ED

30 full assessments in ED that would not otherwise have taken place, of which **18 avoided non-elective admissions as a direct result of ED assessment for this cohort in the ~2wk period**

Mental health winter funding schemes 17/18

Leicester, Leicestershire & Rutland

Enhanced MH triage service to A&E (£88k) : usually the team struggles to meet its 1-2hr response standard for mental health referrals in A&E, especially when demand is high

17/18 winter monies used to increase the capacity of the team (temporary staffing), during the busiest shifts, enabling quicker assessment and discharge from A&E

Baseline response time was 5.12 hrs (average of 8 weeks prior to commencement of the pilot)

Average A+E wait times for MH assessment during pilot:
2.19 hrs

Ambulance mental health triage service (£66k)

Activity for the scheme to 7th March comprises:

22 face to face assessments

4 telephone assessments

42 diversions from A&E

34 advice given to crews

2 transport provided for s135/6

Enhanced call handling/triage/home treatment capacity in Crisis and Home Treatment Team (CRHT) (£115k):

17/18 winter monies used to increase capacity within the Crisis Team, enabling reduction of waiting time to assessments in community, as well as better continuity for patients, with fewer handovers between staff

Baseline response time was 21.9 hrs (average of 8 weeks prior to commencement of the pilot)

Average Crisis response times during pilot: 17.2 hrs

Mental health winter funding schemes 17/18

Barnsley: discharge coordinators (£55k)

- Ensure discharge assessments/planning take place within 72hrs of admission addressing actions required to expedite delayed transfers of care, and working into ward rounds to assist with identifying early discharges, attending patient reviews every week. Also joining home treatment visits to prevent issues escalating to admission
- Typically includes early support with common issues, such as supporting tenancy, benefits, finances, accommodation

Impact vs same period in 2016/17:

- **8% reduction** in the average LOS

Discharge vs admission rate:

- 2016/17: 56 admissions / 39 discharge **(70%)**;
- 2017/18: 41 admissions / 52 discharges **(126%)**.

North Staffordshire (£68k):

- More staff and extension of home treatment team to 24/7 hours of operation

During January the extension of the HTT has **prevented 64 of the 68 referrals received from attending the ED** at Royal Stoke Hospital

Annex A: 2017/18 Mental health winter monies regional proposals: selected themes

Front door

- MH expertise within ambulance services
- Street/community triage' with ambulance service
- Setting up new/Enhancing existing alternatives to admission e.g. crisis houses, cafés
- A&E front door diversion/streaming e.g. through peer-support in-reach into A&E, VCS alternatives

In-hospital

- Expanding liaison capacity (CYP, adults, older adults, dementia) e.g. for rapid assessments in A&E, working on admission wards

Out-of-hospital

- Expanding CRHTT/Single Point of Access capacity (including age range – CYP, older adults; working hours)
- Expanding capacity & working hours of VCS services
- Dementia/frailty/older people's MH in-reach (acute hospitals, care homes) & outreach (community)
- IAPT-LTC proactive in-reach for those at risk of re-attendances and readmissions
- Risk stratification to proactively identify and care for those in the community at risk of crisis and therefore A&E attendances/inpatient admissions e.g. people with dementia
- Earlier intervention to prevent crises through e.g. more psychology input in primary care, VCS outreach to vulnerable groups

Addressing pathway delays or gaps in services

- Mental Health Act (AMHPs particularly OOH, transport)
- Improving substance misuse services (expertise embedded within liaison teams, or community services)
- Acute MH bed management to address delays and OAPs e.g. through discharge co-ordinators, focus on housing support, bed hubs, step-up/step-down beds, block purchasing of extra bed capacity
- High intensity workers focussing on frequent attenders/high users of services
- Increase Psychiatric Decision Unit capacity and throughput
- Digital dictation to improve efficiency
- Education / training of A&E staff and police to speed up flow and reduce avoidable A&E attendances

2. Further examples of mental health schemes that help alleviate operational A&E pressures



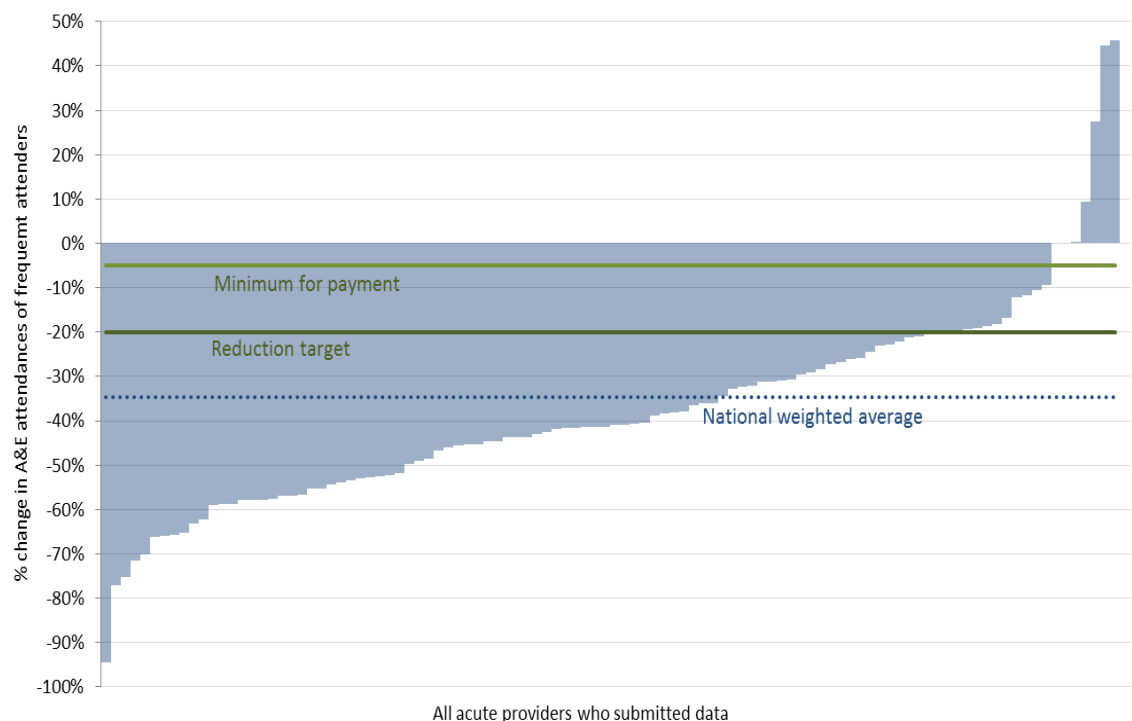
Operational Responses:

Frequent attenders to A&E: National CQUIN 4

- National CQUIN 4 asks every MH and acute Trust to work together to identify shared cohorts of people who attend A&E most frequently and to put in place measures to meet their needs in a better way
- There is growing evidence that the vast majority (c75-85%) of the most frequent attenders to A&E (whether presenting with physical or mental health needs), can benefit from mental health interventions.

In year 1 of the national CQUIN, **84% of providers achieved the target of 20% reduction in attendances** in cohort of frequent attenders to A&E identified as potentially benefitting from psychosocial interventions

Nationally, the cohort of frequent attenders was around **3000 people, with a 37% average reduction in A&E attendances** for these people. **c55,000 attendances in 16/17, reduced to c30,400 in 17/18**



Case studies: approaches to frequent ED attenders

Bristol high intensity user project

- 900 patients per year are ED high impact users.
- Mental health and/or drug & alcohol and/or homelessness in almost all patients
- 'Super users' up to 70 attendances/year, generating costs of up to £30k each in one year from HRG ED attendances and admission tariff alone

Intervention:

HIU nurse coordinator 3 days per week; 4hrs of ED consultant time

- Making individual Patient Support Plans
- Conducting risk assessments for each patient
- Behavioural contracts in violent and aggressive patients
- Crisis planning for alternatives to ED
- Proactive community support scheme
- Referrals where appropriate e.g. medically unexplained symptoms clinics

Impact:

- Reduction in ED attendances and admissions up to 80% in super-user group
- Further reduction of 20% in CQUIN group, equating to £940,000 savings in this group alone
- Improved staff and patient experience scores

West Kent CCG frequent service user project

- 154 people attended more than 10 times in 2015/16
- 25 of these more than 20 times
- Totally 749 attendance

Intervention

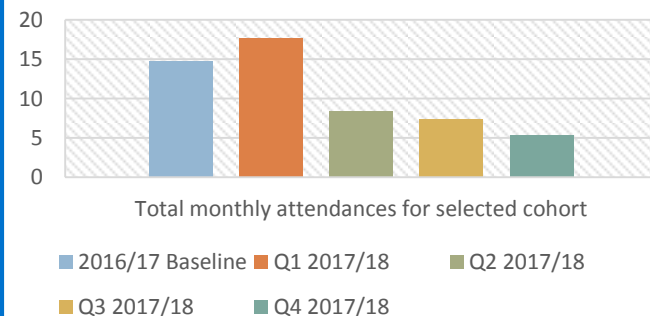
- 1x FSU manager, 1x specialist clinician
- Biopsychosocial assessment and care planning
- Build trust / relationships, home visits
- Advocacy and liaison with multiple agencies
- Clinical interventions where needed, CBT approaches to drug/alcohol, chronic pain, suicide prevention

Impact:

- 94 fewer attendances to ED (40% reduction)
- 52 fewer emergency admissions (47% reduction)
- 57 fewer ambulance conveyances (40% reduction)
- £120,000 saving

Oxford ED frequent attendee project

- 1000 people accounting for over 8000 attendances, but more importantly require much more resource and time than is available to ED shop floor staff
- Mental health emergencies and underlying psychiatric conditions constitute a particularly large part of the challenge, as well as substance use, isolation
- ED team and MH Liaison service implemented joint meetings to discuss shared population of frequent attenders and case management for most challenging
- **64% reduction in attendances in 17/18, equating to £381,000 saving**



Strategic Responses: Alternatives to A&E attendance & in-patient admission

While A&E is necessary for some urgent mental health needs (e.g. when someone has self-harmed) there are out of hospital models that are working successfully to divert people to settings that better meet needs while providing improved patient experience. Most commonly, through:

1. Provision of responsive, 24/7 community crisis response services with clear, open access that can meet urgent / emergency needs in people's homes.

2. Alternatives to A&E for people whose needs are escalating to crisis point, or who may not require specialist NHS response (often voluntary sector led – typically called crisis cafes, havens sanctuaries)



Mental health

Late-night cafe can keep people with mental health problems out of A&E

Safe Haven project that offers out of hours coffee and support is helping to prevent emergency psychiatric admissions



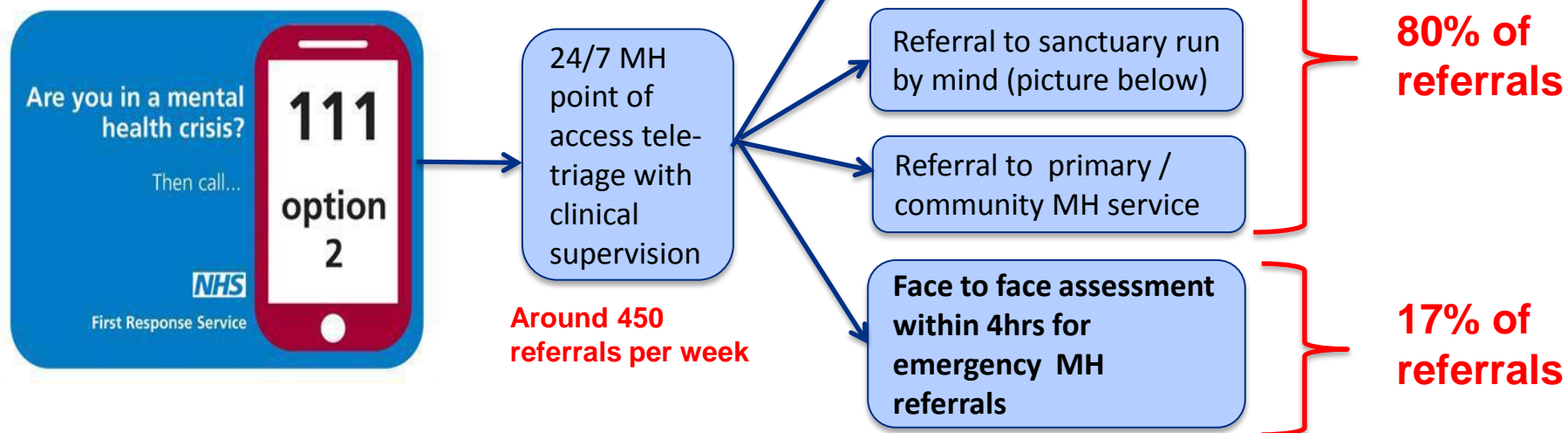
▲ The Safe Haven out-of-hours café provides a safe space to talk about mental health issues. For many people in crisis it is preferable to a 'painful' wait in A&E. Photograph: James Drew Turner for the Guardian

In many areas, these community services do not exist or are not accessible when needed, meaning the only option is to either not access any help at all, or to dial 999 / go to A&E even if this isn't the best way to meet needs. Once at A&E, the chance of a decision being made to admit the person increases.



Case study, community crisis response: Cambridge & Peterborough First Response Service + Sanctuary (all ages)

C&P's model was partly pump-primed through 15/16 system resilience (winter) monies as part of the UEC vanguard programme



Activity in first 6 months of FRS

- **25% reduction** in A&E MH attendances
- **19% reduction** in emergency admissions
- **26% reduction** in ambulance see, treat, convey
- **39% reduction** in OOH GP
- **45% reduction** in NHS111
- **Reduction in MH demands for Police**
- **20% reduction** in home treatment caseloads

Costs: £3.2m (£3.1m for FRS + £360k sanctuary) (878,000 pop)

Savings: £4m (including £2.8m reduction in CCG tariff payments to acute). Business case made for recurrent funding following 1 year of pump prime / set up costs

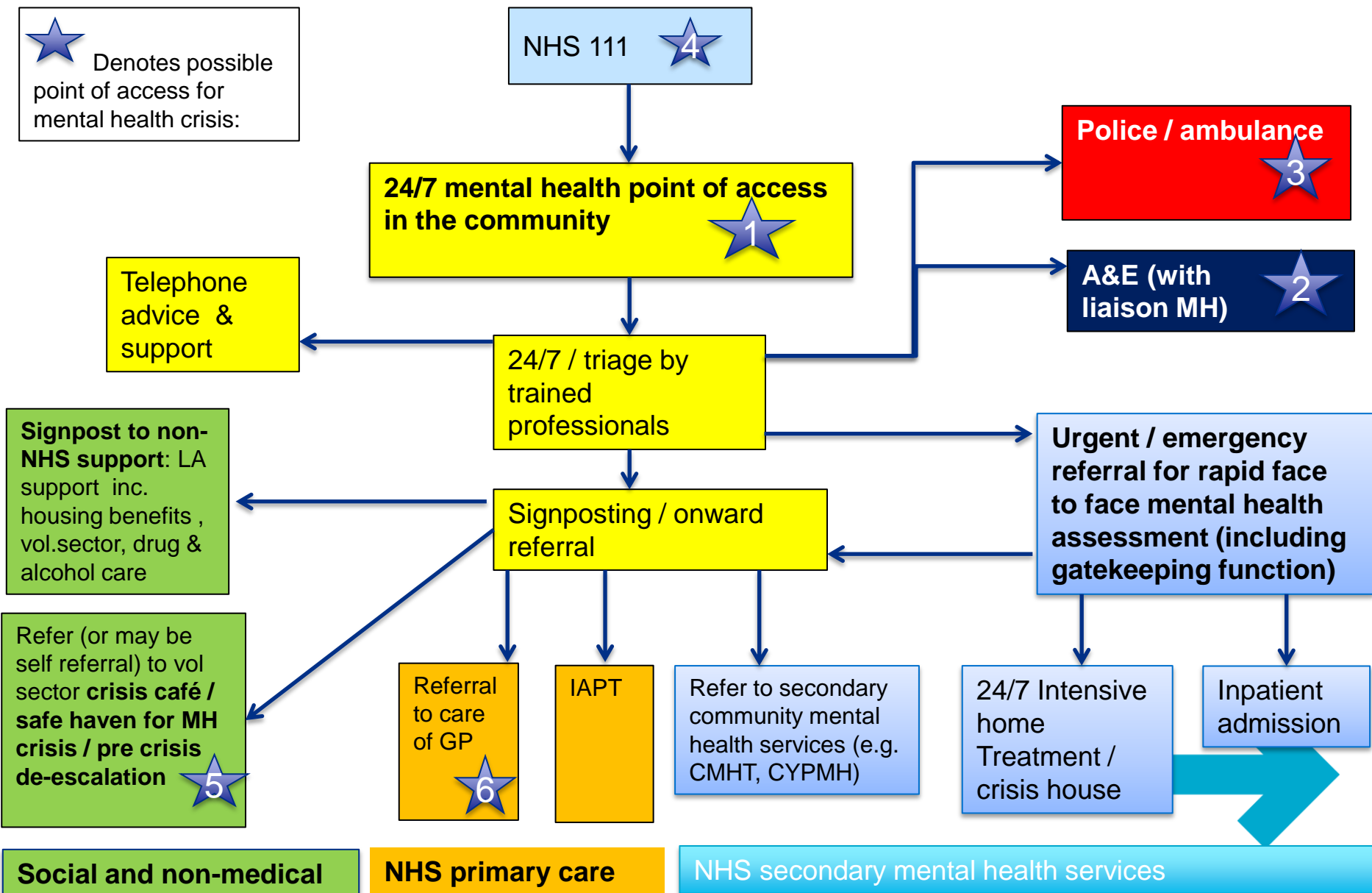
Patient experience

- **72% of people report a good or excellent experience** of the first response service.
- This compared to **only 14% of people nationally** who report a positive experience of crisis services (CQC, 2015)



Sanctuary is a preferable environment to A&E for many people with mental health needs

Building on good practice: a standard offer for community MH Crisis services?



Building on Good Practice: a standard offer for 24/7 mental health liaison in A&E and general hospital wards

When people with mental health needs attend A&E, they would typically require a psychosocial assessment and intervention from an expert mental health clinician before they can be discharged safely. Otherwise:

- people end up being admitted to be kept safe until a mental health professional can come to assess them (this can be hours or even days)
- people are discharged without having had their needs met, potentially unsafely at a higher risk of suicide or self-harm

24/7, on-site mental health liaison ensures:

- The **4hr standard can be met** for people with mental health needs;
- **80-90% of mental health attendances can be assessed and discharged safely** from A&E who might otherwise need admission;
- **Reduce length of stay by at least 1-2 days** on average for people admitted to wards
- **Ensure admissions are short stay only (0-1 days)**
- **Improved experience, quality and safety**

A&E depts can be distressing environments for people experiencing mental health crisis. **Capital funds can be used for safe, discreet assessment areas can provide a calmer space for mental health crisis, than busy A&E departments / cubicles**

Case studies: preventing mental health admissions

Psychiatric decision unit, South West London

- The Lotus assessment suite provides a safe and stable, calming environment away from A&E 24/7/365. It is not a ward and does not have beds
 - It aims to reduce admissions through the provision of a more prolonged and informed assessment of needs/risk (up to 48hrs) and agree the right follow up support.
- 95% positive patient experience
 - *28% reduction in 0-5 day admissions*
 - *66% discharge rate*
 - *Nursing Times award*

Northamptonshire crisis house, The Warren

- Provides alternative to admission that is not only more suitable for some people but significantly lower cost than inpatient admission
 - A number of people attending A&E diverted to crisis house rather than admission to MAU in acute hospital, or out of area inpatient admission
 - Relatively low running costs of £234,280 capital and recurrent costs of £427,319
- Appears to have prevented 20% increase in bed occupancy that was seen in the North of county (with no crisis house)
 - 290 admissions over 12 months with 74% believed to have averted MH admission
 - £800,000 saving on tariff payment to acute trust & on out of area MH admissions

Case studies: North East London & Wirral intensive home treatment teams

- Most intensive home treatment teams are not resourced sufficiently to provide a genuine alternative to admission
- Where they are operating to fidelity, they are an essential component in managing acute MH pressures, and ensuring local mental health beds are always available. Two examples:

Wirral intensive home treatment team

Staff: 41 WTE, 340,000 adult population. Includes 12 support workers supporting 20 band 6 crisis clinicians. 4 AMHPs also included within team complement.

- Resourced to meaningfully gate keep all admissions 24/7 and consider community alternatives
- HTTs have lead role in determining discharge date from inpatient care
- April 2017 to March 2018 they received 2374 referrals and home treated 878 individuals. This was above target of 672.

North East London intensive home treatment teams

Staff: 101 WTE, adult population 810,000

- Single point of access
- HTTs involved in all inpatient admissions and discharges
- Of those seen by the access service only 2% are referred to acute mental health services, and 70% are treated and discharged back to primary care

Both of these teams work in areas that have among the very lowest mental health inpatient bed base but are also among the few to have maintained zero out of area placements. Resource that would otherwise be spent on inpatient care is invested in the community to ensure that community care is the default but a local mental health bed is always available when needed, including when being referred from A&E