Preparing to implement mental health access and waiting time standards

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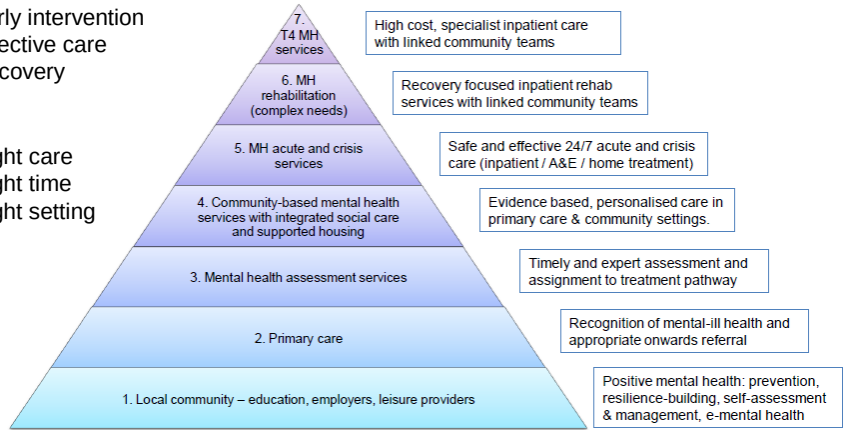
Presentation summary

1. Brief overview of context
2. The standards to be introduced from 15/16
   - Early intervention in psychosis
   - Liaison mental health
   - Psychological therapies
3. Other access work
   - Perinatal mental health
   - Eating disorders (CYP)
4. Planning and assurance

MH 5YP: rebalancing the system

- ✓ Prevention
- ✓ Early intervention
- ✓ Effective care
- ✓ Recovery

- ✓ Right care
- ✓ Right time
- ✓ Right setting



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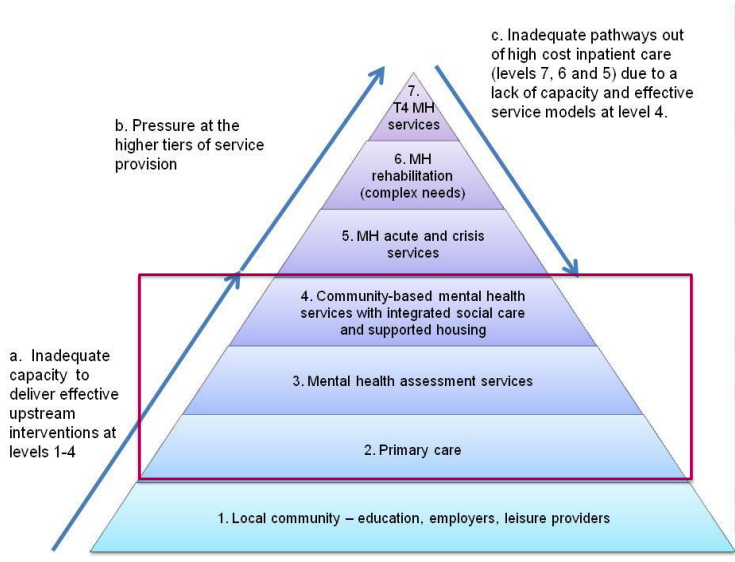
The system is currently not in balance



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

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Access and waiting times are part of a wider commitment to parity of esteem for mental health...

"To make parity of esteem a reality by 2020… we need standards for access to mental health treatment for people of all ages that **balance the equivalent standards for physical health**. We need the same quality of data and transparency about performance for mental health services for people of all ages so that **long waits for effective treatment are visible and have to be tackled**… People of all ages with mental health problems should receive at least the equivalent level of **access to timely, evidence-based, clinically effective, recovery focused, safe and personalised care** as people with a physical health condition."

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, held in CCG baselines; indicative tariff uplift to providers

Improving Access to Psychological Therapies
- 75% treated within 6 weeks, and 95% within 18 weeks
- £10m non-recurrent, held in NHSE programme funds

Liaison Psychiatry
- Support effective models of liaison psychiatry in a greater number of acute hospitals
- £30m non-recurrent, held in NHSE programme funds

2a Autumn Statement
December 2014

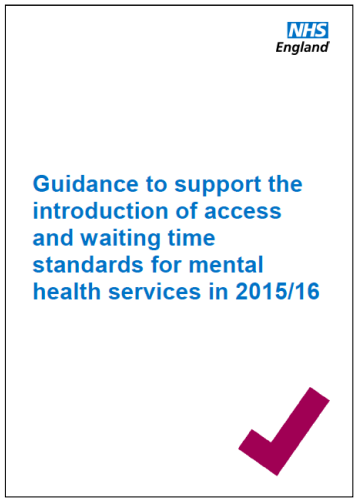
Eating Disorders
- Improve CYP access to specialist evidence-based community services
- £30m recurrent, held in NHSE programme funds

2b Budget
March 2015

Perinatal
- Process underway to inform allocation and implementation
- £15m recurrent, held in NHSE programme funds

3 The Mental Health Task Force, chaired by Paul Farmer (Mind), is producing a costed five-year plan for the NHS to improve mental health services. This may include further standards

Initial guidance – Feb 2015



1. Clarify the requirements of each of the new 15/16 mental health access and waiting time standards and associated expectations of CCG commissioners in line with NHS England planning guidance.
2. Outline the intention to implement access and waiting time standards for eating disorders in community CAMHS from 2016.
3. Update stakeholders regarding the national programme of support for implementation of the new access and waiting time standards.
4. Signpost stakeholders to helpful sources of regional support for implementation of the early intervention in psychosis standard.

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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 provider**s**, setting out how providers will work to ensure there are adequate and effective levels of liaison psychiatry 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.

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National approach to implementation	
1. Bringing together the required expertise	National expert reference group, NCCMH 'hosting', highly collaborative.
2. Developing the required dataset	Specifying the dataset, developing the MHSDS and commissioning national clinical audit & accreditation scheme
3. Publication of commissioning guidance	Service specifications, service model exemplars, staffing / skill mix calculators etc
4. Design of levers & incentives	Planning guidance, payment system development, standard contract etc. Engagement with Monitor, TDA, CQC.
5. Implementation support	Regional preparedness programmes, national events etc.
6. Workforce development	Joint work with HEE

2. The new standards to be introduced from 2015/16

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?

1. We commissioned the National Collaborating Centre for Mental Health to support the programme and establish a reference group of EIP experts to:
   - Design the RTT pathway;
   - Specify the interventions that would need to be captured;
   - Specify the outcomes dataset.
2. We worked with the HSCIC and provider information experts to agree the associated changes required to the MHLDDS and the timeframe for delivery. The changes to provider information systems and the new MHSDS should take effect **from 1 January 2016**.
3. We established 4 Regional EIP Preparedness Programmes and tasked them with undertaking workforce surveys that would provide granular data regarding skill-mix and competencies.
4. We are working with NCCMH and a technical team of experts to develop a **commissioning guide** to support local commissioning and planning
5. We are working with HQIP to commission a **national clinical audit** of EIP services to understand the current level of NICE concordance.
6. We are working with the 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'?

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 £30m to enable a greater number of acute hospitals to establish effective models of liaison psychiatry.
- From 2015/16, when the **Care Quality Commission (CQC)** rates acute services, it will include a specific focus on liaison mental health services and mental health care, as well as the quality of treatment and care for physical conditions.

Where are we now?

- In process of determining how best to use the £30m so that it can address immediate need for liaison mental health across England and in line with NHS England strategic direction for future.
- We are working very closely with the urgent and emergency care review team to embed A&E liaison fully in the urgent and emergency care pathway, and with the Royal College of Psychiatrists liaison faculty.
- We are renewing our crisis care programme to accelerate progress on the actions we have committed to as a signatory the Crisis Care Concordat.

Psychological therapies (adults)

- The new waiting time standard requires that **75%** of people 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. The standard applies to **adults**.
- Services will continue to be required to maintain the **access** standard of ensuring that at least **15%** of adults with relevant disorders will have timely access to IAPT services with a **recovery** rate of **50%**.
- National 15-16 plans show that the 75.7 % and 95.1% will be achieved respectively in Q4; only 3 CCGs are predicting not to meet either standard. Whilst the latest data in March shows that the 6 week (75%) and 18 week (95%) standards appear to be met (78% and 95.9% respectively), there are long waits in services.
- The £10m non recurrent implementation fund is being used to:
  - 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).**
- **Key dates**
- 24th July : Submission of CCG backlog clearance applications for funding
- 17th August : Confirmed offers of funding sent to CCGs for backlog clearance

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Psychological therapies (adults)- achieving sustainable delivery

As we move into in Q4 15-16, the following key areas require focussed attention by commissioners when assuring the credibility of plans for the maintenance of the IAPT Access ambition and the delivery of IAPT waiting standards, ensuring that:

- Processes for reliable data reporting and submission are sufficiently robust.
- The necessary capacity to deliver the 3.75% run rate each quarter, is funded with performance monitoring and contract levers in place to ensure that volume of patients is delivered, separate from any discussion on clearing backlogs.
- The backlog to be cleared to achieve the national waiting standards is agreed with providers with timescales.
- CCGs are confident that providers are operating a fully validated waiting list and any long waits and/or unequal waiting lists are effectively managed and that there are plans in place to address long waits for particular locations/localities/therapists and for particular therapy types.
- There is a good understanding of the requirements for sustainable delivery and challenge of the 15% and 50% ambitions.
- **For IAPT recovery,** the following support is planned:
  - Leadership and Training events accompanied by re-launch of the IAPT "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 individual providers) (October)
  - Establish a consensus on factors that limit potential for recovery (e.g. deprivation) (October)

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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
Will meet 3 times: June, July, 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)

Work is in development and ongoing

- **Working with NCCMH Expert Reference Group** to develop access and waiting time standard, referral to treatment pathways and model for delivery of dedicated community eating disorder services for children and young people.
- Working with **HEE** on training and workforce plans
- Developing support for commissioners, including commissioning guide.
- Transformation plans will need to demonstrate how monies released or, where comprehensive services are in place, will be used to benefit self harm and crisis
- Guidance should be published at the same time as Transformation Plans.
- As with other areas access and waiting time standard development will focus both on the waiting time and access to appropriate, NICE-concordant treatment

4. Planning and assurance

Achieving parity for mental health continues to be a focus

1. There is significant ministerial interest as demonstrated by **Monthly accountability meetings with SoS** where discussions are focussed on:

   - The delivery of access standards: IAPT, EIP, Liaison Psychiatry
   - Progress on developing to develop a holistic view of Mental health performance looking at trends in out of area transfers (OOA) and DTOCs
   - Developments in other commitments for Liaison Mental Health, the transformation of CYP MH transformation and Perinatal mental health in terms of measurement and proposed use of additional funding
   - Continuing to improve the identification of dementia for the purpose of developing post diagnostic support to people and their families and carers and other standards

2. **NHS England is continuing its support to clinical commissioners** in mental health delivery and as a result:
   - Mental health has been a key area of focus in the 2015/16 planning round
   - A more proactive approach is being developed to achieve a nationally consistent well informed view of performance and the associated risks and issues through:
     - Regular coordinated monitoring of performance and risk assessment
   - We are ensuring the mental health contribution to system resilience is hardwired in the current SRG assurance work this year

A proactive approach to a nationally consistent well informed view

3. We are learning lessons from the experience of Q3/Q4 last year to get on a more proactive footing as an organisation in communicate confidence in current and future performance more effectively to other national organisations.

   To achieve this we are working with regions to implement a system to routinely collate qualitative information in areas where specific underperformance is evident to understand:
   - The core causes of underperformance
   - Actions in place to address these within the local health economy
   - Timeline by which standards will be achieved against the constitutional and key commitments including MH
   - Only the highest risk organisations will be escalated to the national level for support

   This will build on existing processes so that :
   - Planned delivery remains with CCGs and primary care commissioning
   - Oversight and assurance function is retained by regions and DCO teams in the delivery of CCG plans
   - Central teams can focus on developing and coordinating improvement support and a well-informed view of national progress and delivery.

Central NHS England (Medical) programme leads will co-ordinate the clinical support and improvement programme, through the regional medical leads, and supported by the National Clinical Director, Intensive Support Team (IST), Clinical Networks (CNs), Allied Health Science Networks (AHSNs) and other Arm's Length Bodies (ALBs).

Strengthening the mental health contribution to operational resilience

4. We continue to seize every opportunity to ensure that the impact of mental health on the wider system pressures is recognised.

One of the key developments this year is the inclusion of mental health as one of the key six areas which SRG's are to provide assurance on, in terms of their current position and development needs. Though not confirmed, it is likely that SRGs may be asked to assure the robustness of:

- The mental health representation in SRGs
- The provision of comprehensive24/7 A&E MH liaison services as part of the solution to wider system pressures affecting operational resilience
- Systems in place to manage and report mental health acute bed occupancy including out of area placements
- Systems in place to support repeat mental health users of urgent and emergency care services

It is the intention is that the tool to be used as part of the SRG self assessment element of the assurance process will be supplemented by good practice information and will sign post to additional support to help SRGs in areas which they identify as needing further work.

For MH, it is proposed that linkages are strengthened with local crisis care concordat implementation groups for an effective and seamless approach to ensuring that people in crisis are supported in the right place and at the right time.

Where we are now

- A substantial increase in the highest level of achievement so far in the dementia diagnosis rate, which has risen by almost 10% to 61.6% in March 2015, compared to the same time last year.
- The highest annualised access rate in March 2015 (17.2%). Based on the last three months of data; this gives an indicative performance of 15.6% for the Q4 2015-16 IAPT annualised access.
- The highest access and referral rates (24.2%) being achieved for IAPT.
- Improved access to IAPT services for CYP covering 68% of the 0-19 population.
- Early Intervention (EI) teams served 10,186 new cases of psychosis from April 2014 to March 2015.
- 97.2% of patients under adult mental illness specialties on Care Programme Approach (CPA) were followed up within 7 days of discharge from psychiatric inpatient care.
- 98.1% of admissions to psychiatric inpatient wards were gate kept by Crisis Resolution Home Treatment (CRHT) teams.

Where we are heading to in 2015/16

We want to build on what we have achieved so far through:

- Continued investment to improve MH services through the requirement for MH spend to rise in real terms in each CCG and grow at least in line with each CCG's overall allocation growth
- Sustained delivery where IAPT and dementia ambitions have been met
- Achieve the ambitions for IAPT and dementia where these have not yet been met, focussing particular support to improving post diagnostic support for dementia and improving IAPT recovery rates.
- Prepare to sustainably deliver from April 2016 , the new access and waiting time standards for IAPT, Early Intervention Psychosis and the effective provision of Liaison psychiatry services across acute settings, supported by the additional resources.

It is also expected that we demonstrate through our planning and assurance processes , effective use of the significant resources made available to transform services including that to CYP mental health, ED and perinatal mental health.

According to 2015/16 CCG plans:

- **In terms of investment in MH services**, CCG plans indicate an increase of 4.6% in mental health programme growth compared to the expected level of 3.7%. This increase includes a centrally held allocation for mental health within plans.
- In a minority of cases where CCGs did not appear to have increased their headline level of mental health spend in 2015-16, in the majority of cases, there are adequate explanations as to why the level of increase is less than expected.
- For **IAPT Access** CCG plans suggest that the 15% national ambition will be met overall as all except 11 CCGs are aiming to deliver a run rate of at least 3.75% each quarter.
- For **IAPT Recovery Rate** the 50% recovery rate will not be met until Q3, 2015-16. Whilst all CCGs plan to deliver the 50% recovery rate by Q4, 15-16, 22 CCGs are predicting they will not consistently deliver this in each quarter to Q4 15-16.
- For **Dementia**, while 58 CCGs have already met the ambition according to most recent data in March, of the remaining CCGs who have not, 59 are at least 10% adrift from the ambition.

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Assuring delivery for mental health

- ☑ **Prioritise clinical engagement**
- ☑ **Planned delivery will remain with CCGs and primary care commissioning**
- ☑ **Oversight and assurance function retained by regions and DCO teams in the delivery of CCG plans through the CCG assurance process**
- ☑ **There will be quarterly discussions between national and regional colleagues on progress being made in the delivery of CCG plans in their area and any additional support required.**
- ☑ **Proactive communication of current performance against plan will continue e.g. Dementia, IAPT data pack**
- ☑ **A proactive approach to gathering qualitative information for a well informed view on performance will be embedded**
- ☑ **Strengthen the mental health contribution in achieving operational resilience in the wider system**

This will be also underpinned by:

- ☑ **Closer working and alignment between the IST and clinical networks to ensure equitable access to improvement support expertise where required**
- ☑ **Focussed support via IST to a small number of organisations with significant risks.**

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