Preparing to implement mental health access and waiting time standards

Sarah Khan

NHS England

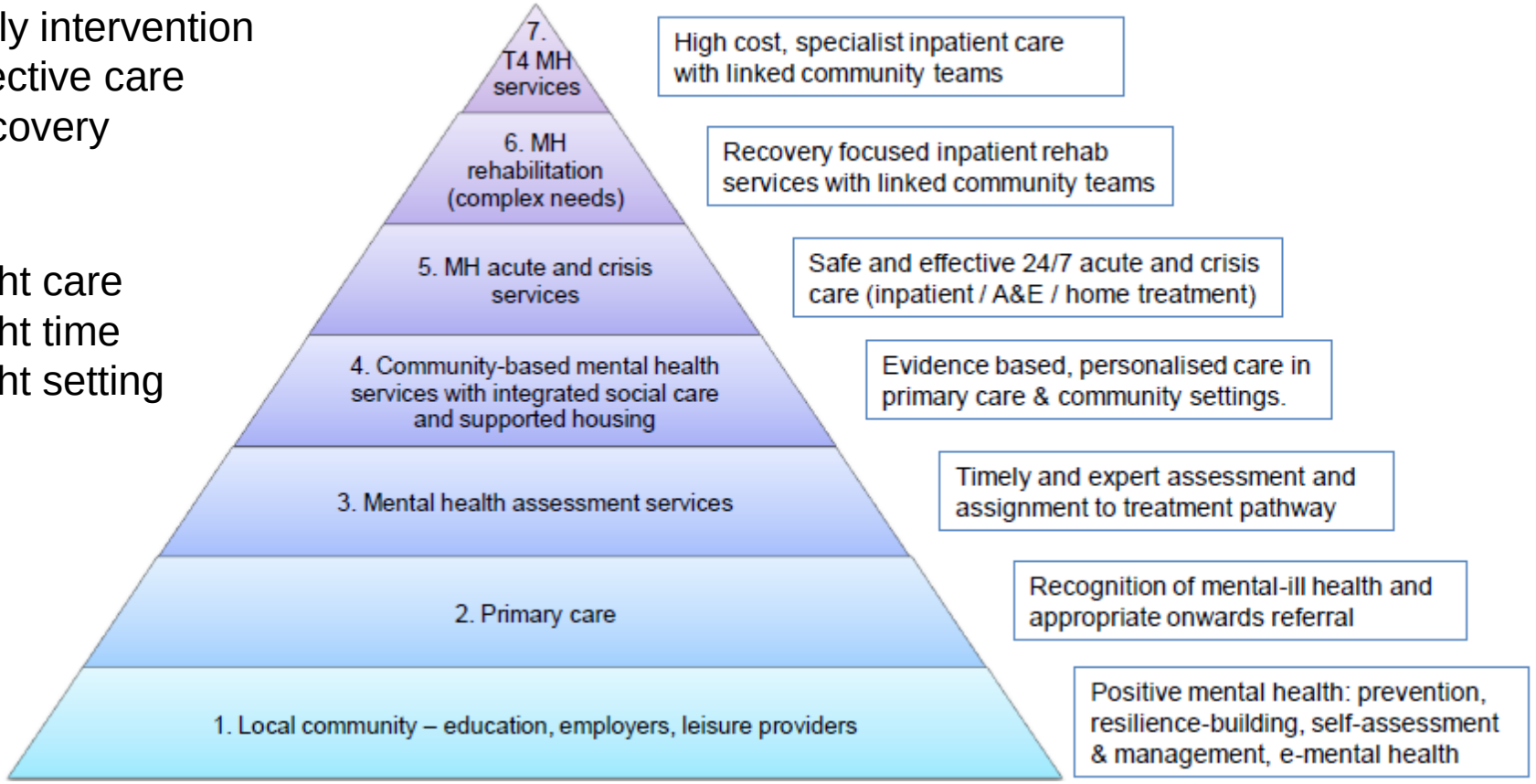
Presentation summary

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



The system is currently not in balance

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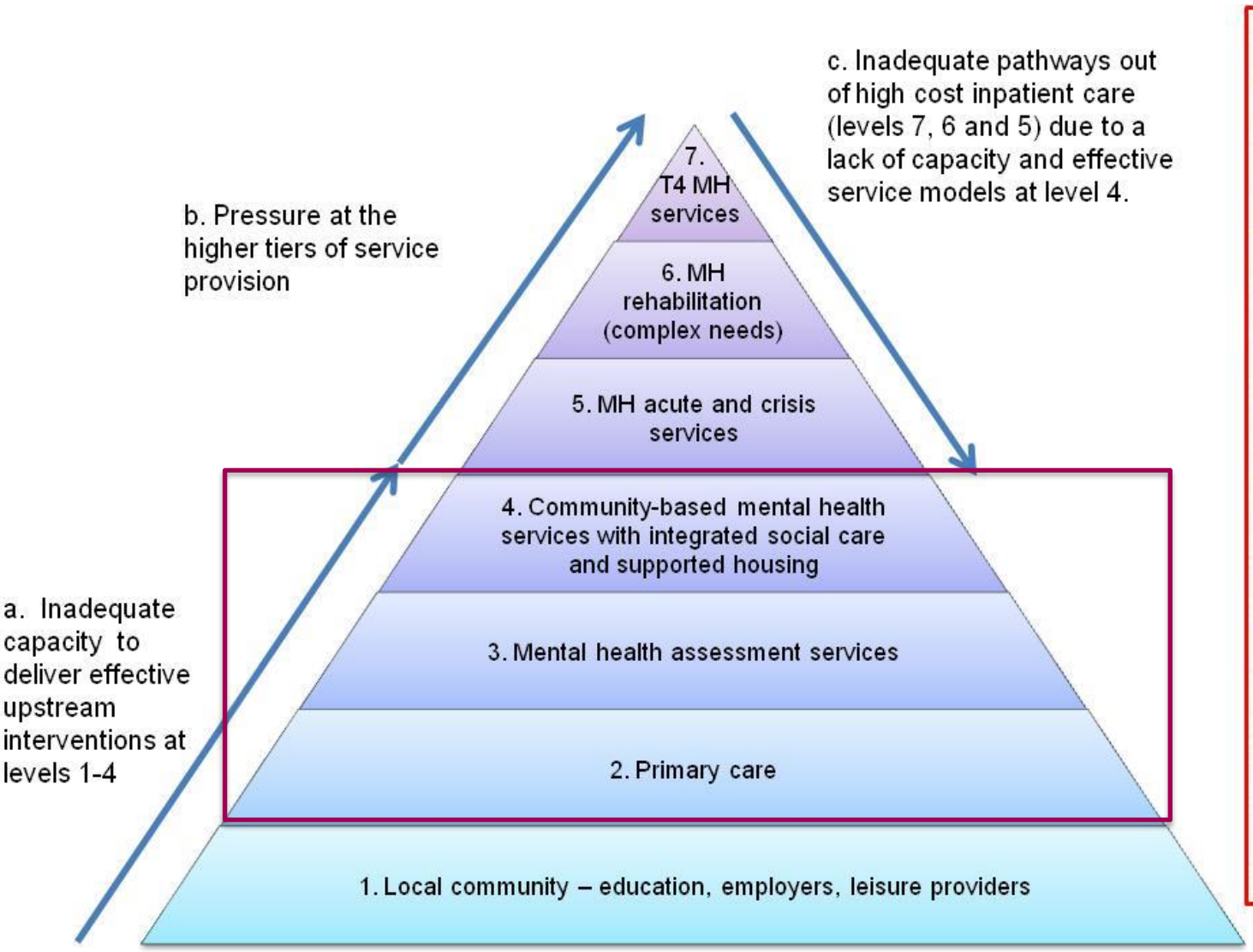


a + b + c

= 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

Dr Geraldine Strathdee
Mental Health

Dr Jackie Cornish
Children, Young People and Transition

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

Access and waiting time standards in mental health build on existing standards elsewhere in the NHS

NHS England

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

NHS England

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.

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

SUPPORTING THE ACHIEVEMENT OF THE EIP TARGET

EARLY INTERVENTION IN PSYCHOSIS LONDON

LONDON CCGs

NHS

London Strategic Clinical Networks

INTRODUCTION

David Monk: London Project Lead

In this presentation we will:

- Orientate you to the new EIP referral to treatment standard
- Describe demand and capacity in London
- Describe the work we are doing in partnership to prepare London

THE NEW NATIONAL EIP STANDARD

new standard

The new EIP standard was introduced on 1 April 2015 for achievement by 1 April 2016:

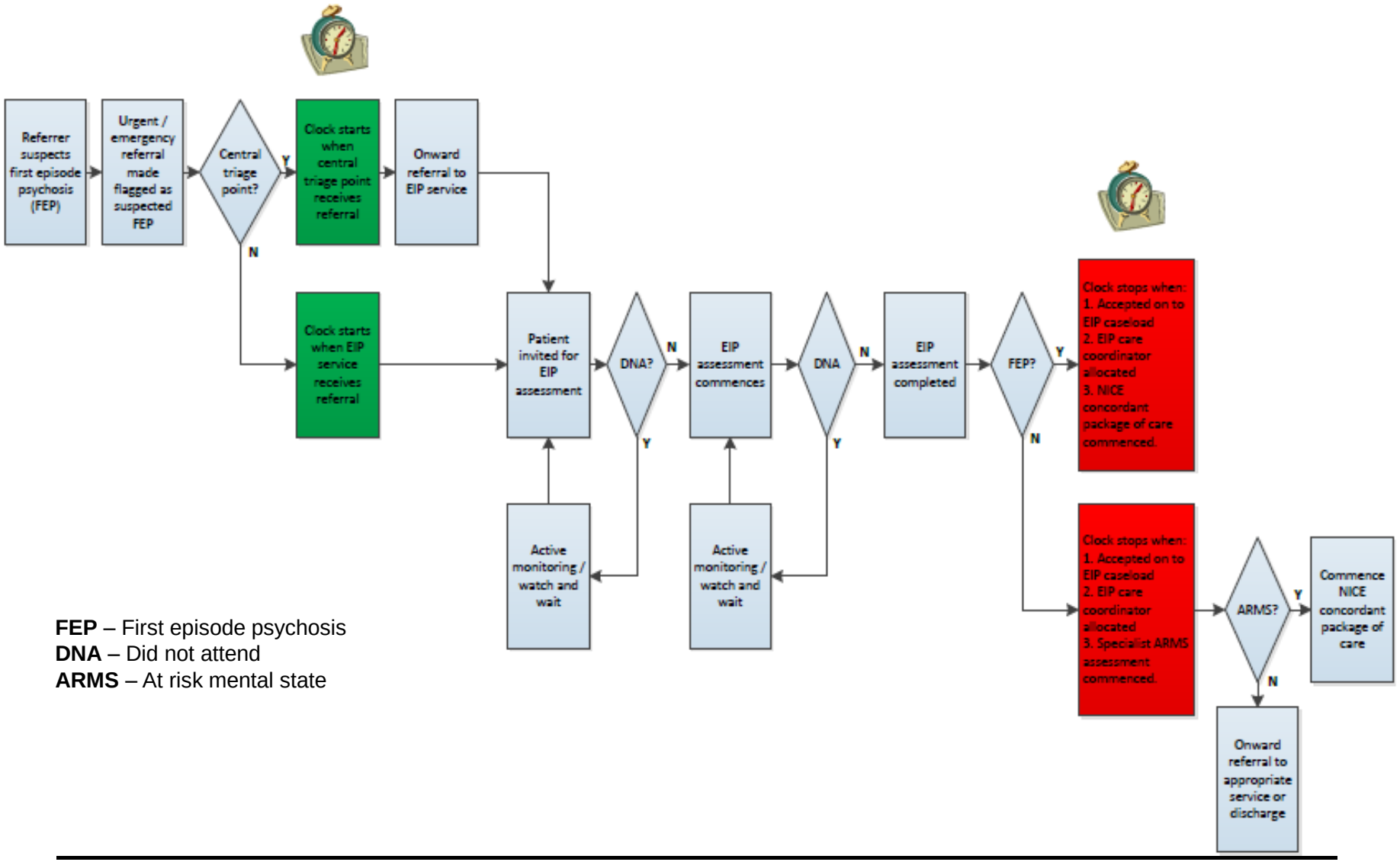
By April 2016, more than 50% of people experiencing first episode psychosis will commence a NICE concordant package of care within two weeks of referral.

referral to treatment time

The EIP Referral to Treatment Time (RTT) pathway outlines the clock start and stop measures for this two week standard.

- They are on an Early Intervention Treatment (EIT) specialist caseload
- Their care is being coordinated by a specialist EIT care coordinator
- The EIT team is preparing their appropriate NICE concordant package of care

DRAFT EIP RTT PATHWAY



FEP – First episode psychosis
DNA – Did not attend
ARMS – At risk mental state

Denominators and Numerators

DENOMINATOR 1: Sum of the number of referrals for suspected FEP to and within* the Trust. (Per month)

NUMERATOR 1: and DENOMINATOR 2: Number of suspected referrals to and within the Trust confirmed as FEP and ARMs. (Per month)

NUMERATOR 2: Number of suspected referrals to and within* the Trust confirmed as FEP and ARMs and in NICE recommended treatment within 2 weeks. (Per month)

- FEP STANDARD: N2/D2 x100% = 50% or more
- FEP 'proxy recognition rate': N1/D1
- Within means suspicion starts once in trust

WHY IS THIS TARGET IMPORTANT?

- The *average* national lifetime risk is **3 in 100. However the risk for people can be at least twice as high – 6 in 100.**
- Delays to accessing treatment and care when first experiencing symptoms of psychosis lead to poorer outcomes and higher use/ cost of hospital care
- Recent research has shown that on average, people with severe mental illness **die up to 20 years sooner** than the general population due to poor physical health
- **The Schizophrenia Commission (2012)** estimated that the total societal cost of schizophrenia was **£12 billion**

PURPOSE OF EIP PROGRAMME

objective

To bring key people, **primarily commissioners and providers**, up to speed with the RTT target, the implementation timetable and the London programme.

Support informed, collaborative working between CCGs and trusts to define local needs and provision, identify particular characteristics / implementation issues at a borough level and develop their plans.

To **signpos**t to other relevant resources and guidance documents.

EIP Preparedness (2015/16)

Informatics [baseline of services and need]	• Prevalence, incidence, deprivation, demand • Service profiles/provision, scope and current resourcing
Clinical Reference Group	• Engaging EIP clinical community • Best Practice – e.g. Pathways and Medication
Engagement	• Workshop series • Communication strategy (newsletter, online platform, conferencing)
RTT Systems learning	• Series of workshops – RTT lessons learnt from cancer RTTs • Development of RTT diagnostic tool at pilot site, roll out for free
Workforce planning	• Capacity, skills, Needs Assessment (Active and Dormant?) & leadership • Delivering NICE compliant interventions? LETBs contact
Metrics	• Data to measure successful implementation • Go live on 1st November (shadow)
Consumer Voice	• Embed voice of those with lived experience • Learning from oral histories etc

THE EXAM Question

Demand

Prepared by UCL partners, this data provides a local needs analysis at a borough level. The data gives an indication of incidence and prevalence of psychosis, the cost burden of psychosis and the current economics of psychosis in London, providing data for each Local Authority, benchmarked with London and national averages.

Capacity

Prepared by the NHS Benchmarking Network, data was collected on a team level from all EITs in London. This data relates to positions reported for the year 2014/15. The data reports on

- Caseloads – patients and activity (focusing on cluster 10), and the diagnosis ‘mix’ in EIS
- Workforce by clinical / professional group, hospital and community-based
- Referral routes
- Performance – current waiting time, length of stay, number of interventions

The incidence rates and number of cases of psychosis in London

Data from PsyMaptic

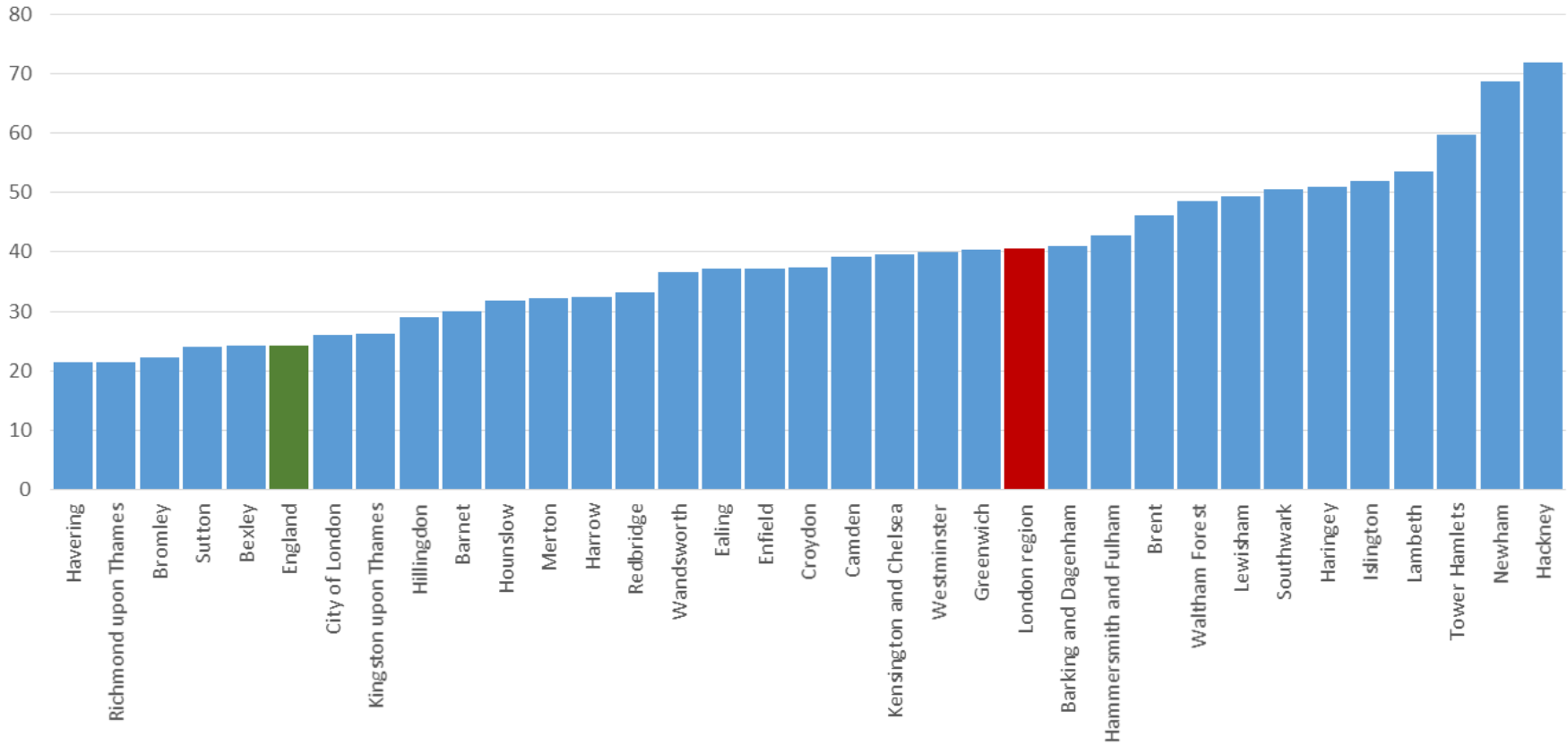
***Kirkbride et al, BMJ Open (Feb* 2013)**

Psychosis Incidence

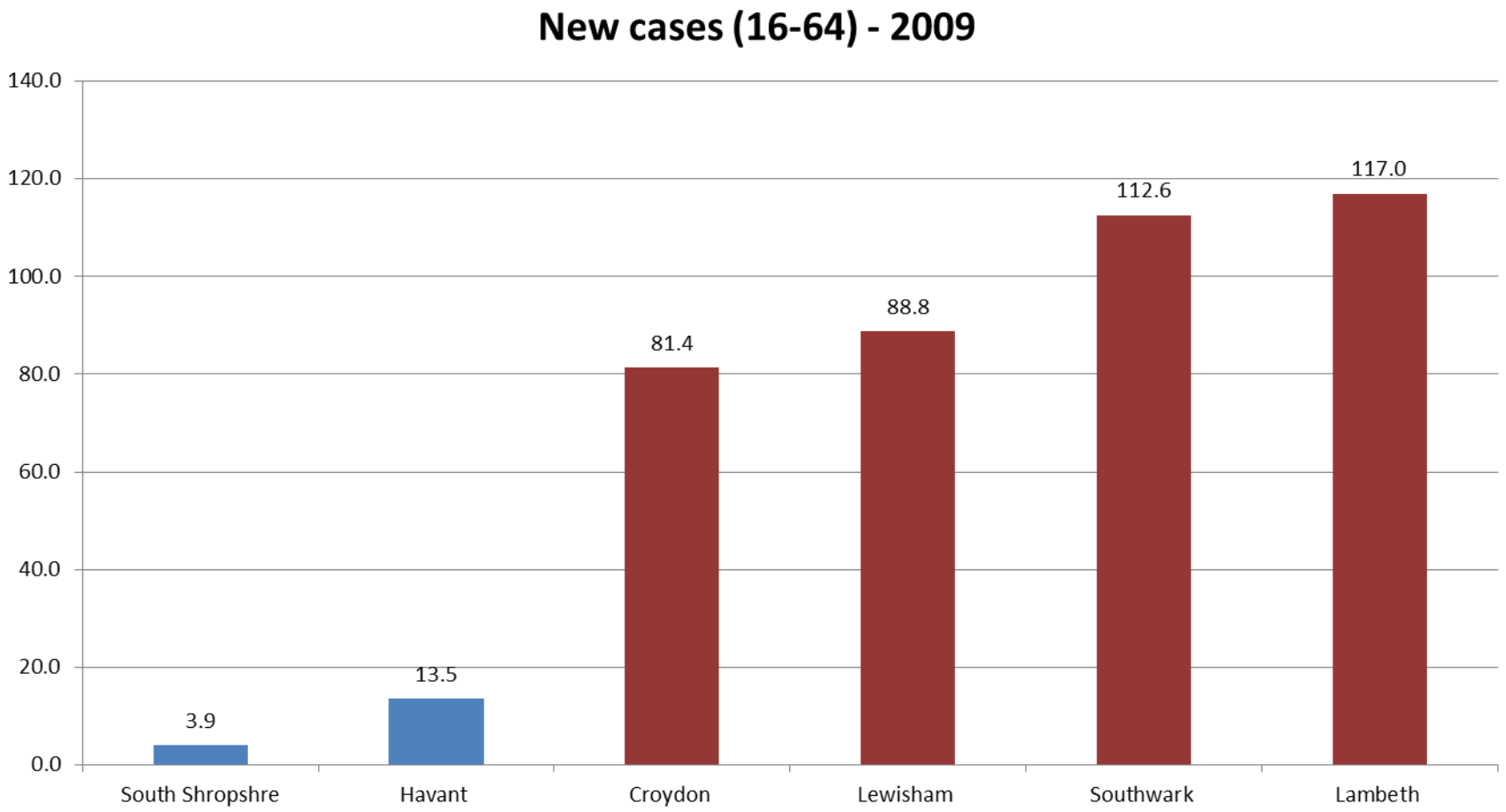
NHS England

New cases of psychosis: Estimated incidence per 100,000 aged 16-64

Source: Fingertips / Psymaptic



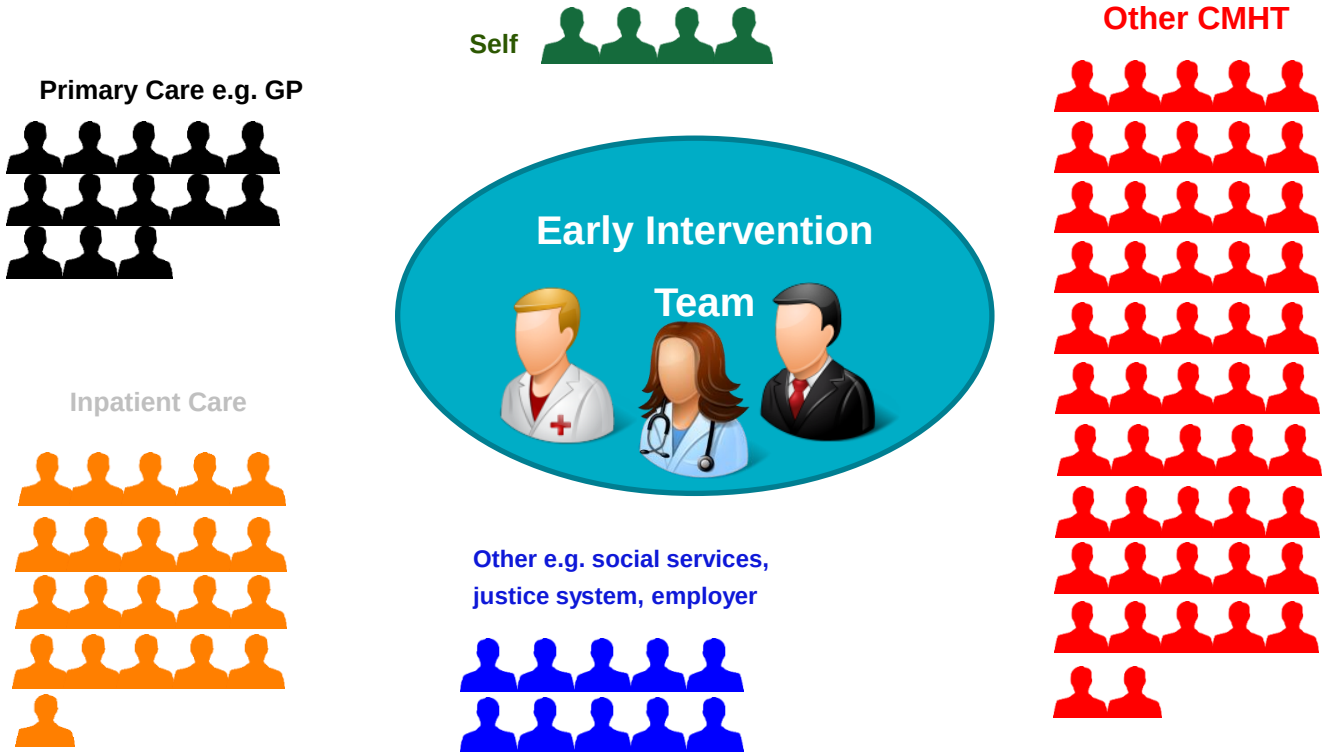
Predicted new cases England and Wales
Local Authorities: Lowest, mid and 4 London boroughs



Early Intervention Headlines

Referrals by source

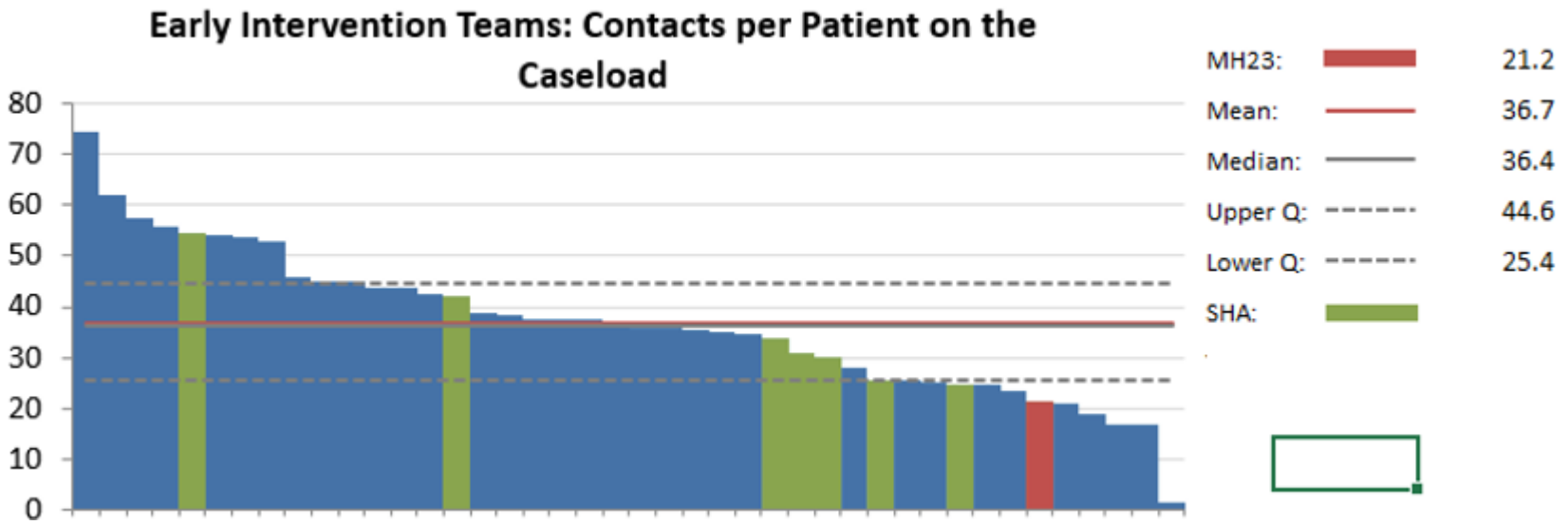
(London EIP teams 2014/15)



Contacts per patient on the caseload 2014/15

Blue = England and Wales

Green / red = London Trusts

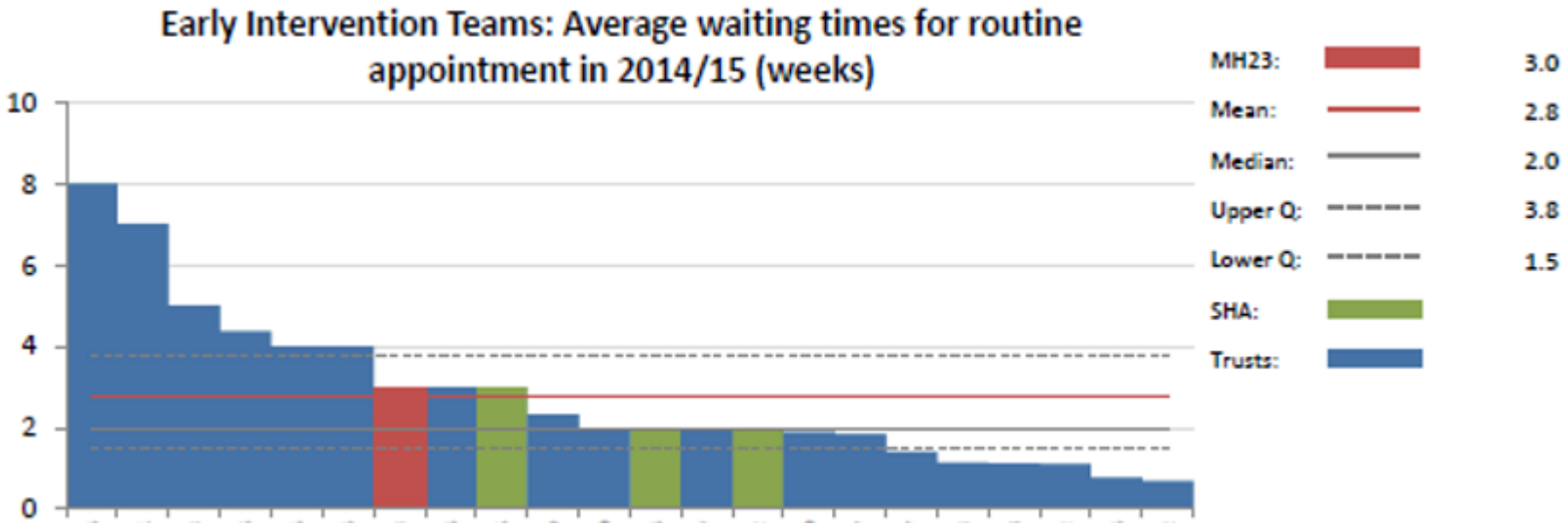


Average wait for routine EIT appointment 2014/15

Blue = England and Wales

Green / red = London Trusts

From referral to TEAM, not first referral to Trust for suspected FEP



NHS Benchmarking Network

EI Headlines 2014/15 (national benchmarking)

Early Intervention

On average, 82% of referrals to EITs are accepted

Waiting Times

2.8 weeks waiting time from referral to first routine appointments

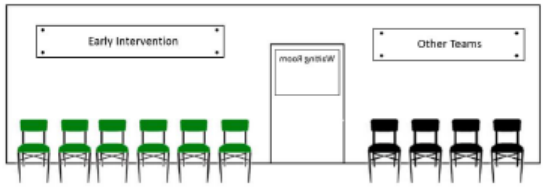
Contacts

37 EIT contacts per service user per year

Cluster 10s

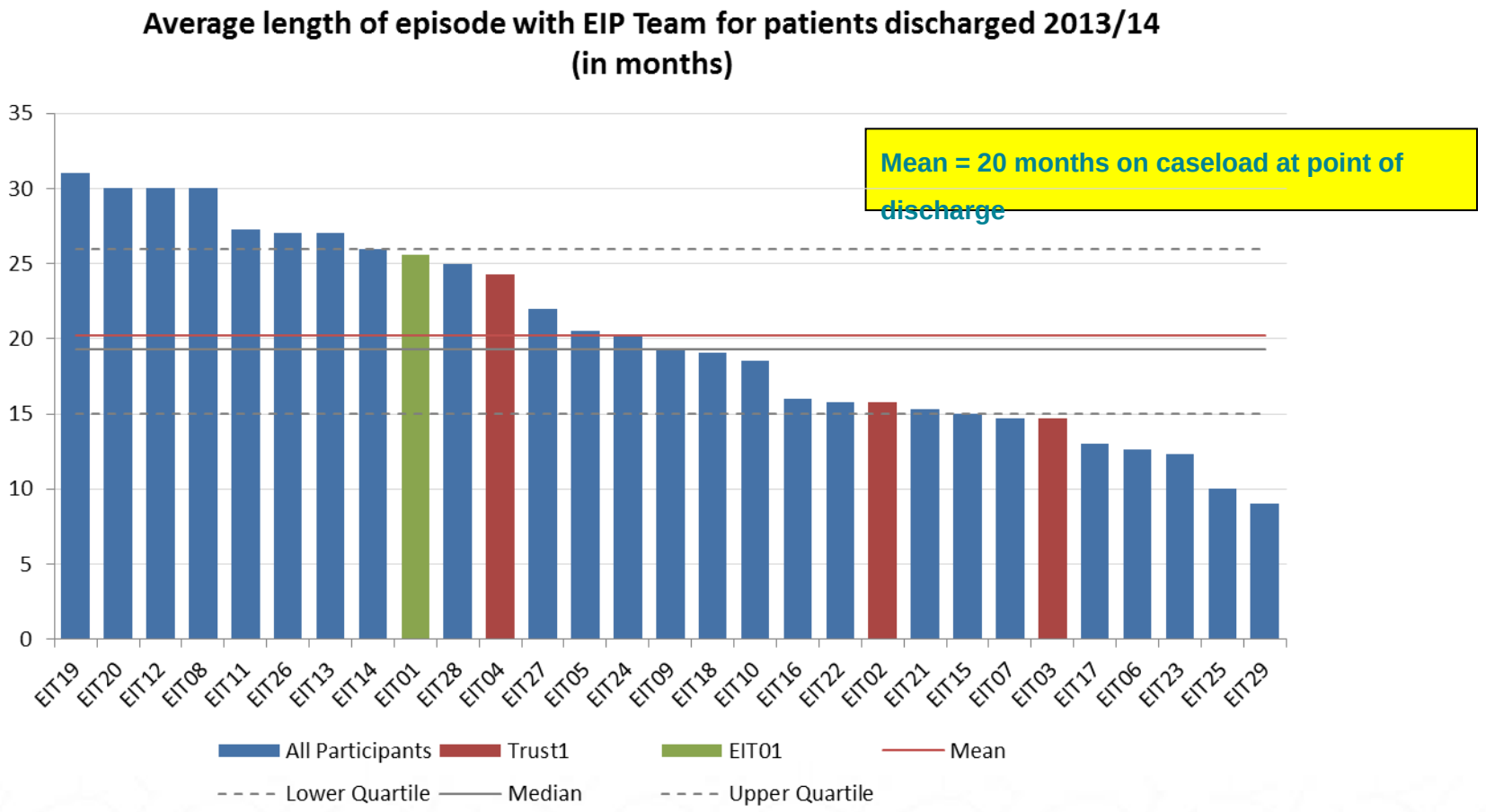
Approximately 65% of community Cluster 10 patients are on EIT caseloads.

35% are managed by other teams.



NHS Benchmarking Network

Average Length of Time on Caseload (London)

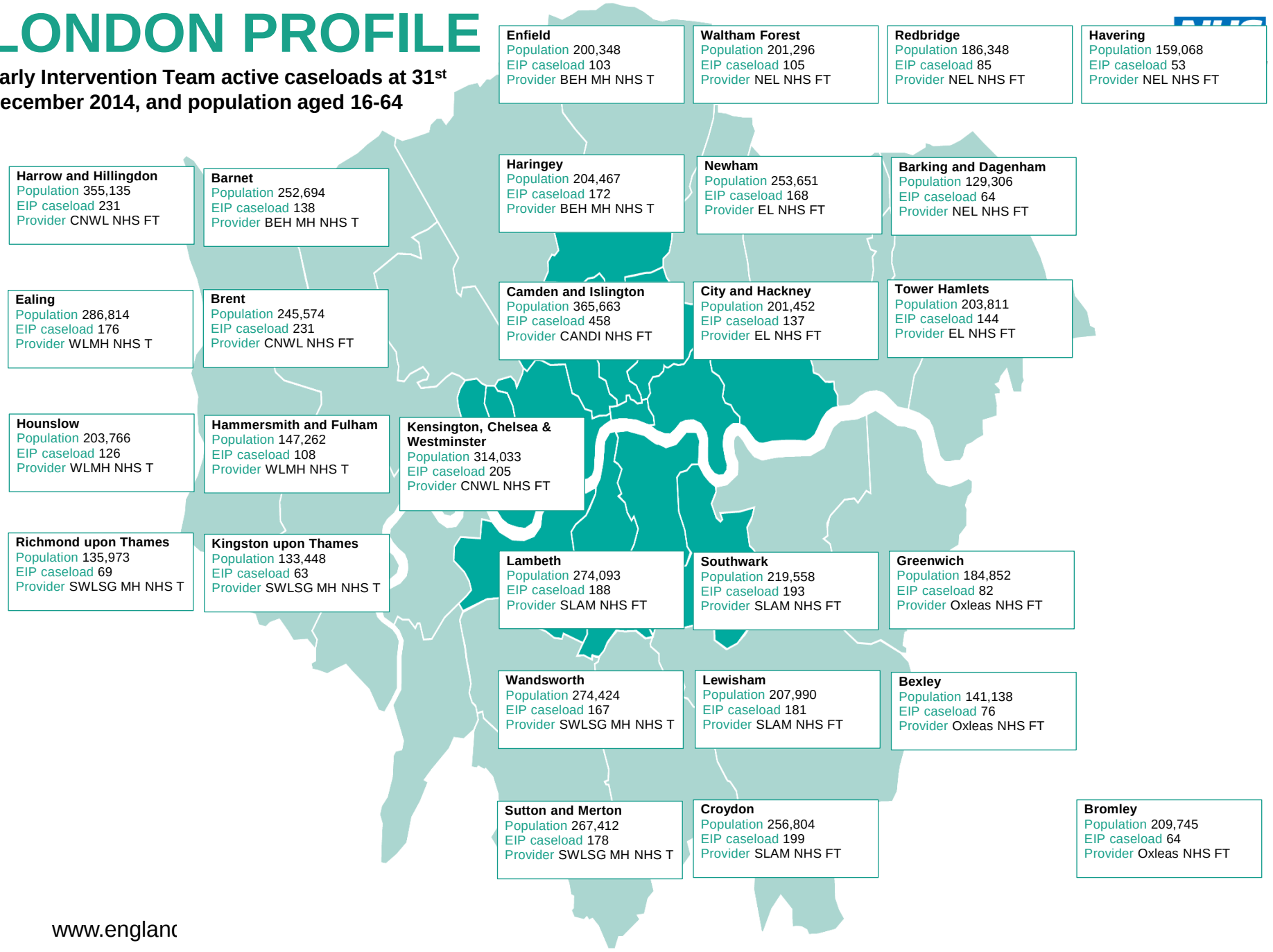


Mean = 20 months on caseload at point of discharge

NHS Benchmarking Network

LONDON PROFILE

Early Intervention Team active caseloads at 31st December 2014, and population aged 16-64



Enfield
Population 200,348
EIP caseload 103
Provider BEH MH NHS T

Waltham Forest
Population 201,296
EIP caseload 105
Provider NEL NHS FT

Redbridge
Population 186,348
EIP caseload 85
Provider NEL NHS FT

Havering
Population 159,068
EIP caseload 53
Provider NEL NHS FT

Harrow and Hillingdon
Population 355,135
EIP caseload 231
Provider CNWL NHS FT

Barnet
Population 252,694
EIP caseload 138
Provider BEH MH NHS T

Haringey
Population 204,467
EIP caseload 172
Provider BEH MH NHS T

Newham
Population 253,651
EIP caseload 168
Provider EL NHS FT

Barking and Dagenham
Population 129,306
EIP caseload 64
Provider NEL NHS FT

Ealing
Population 286,814
EIP caseload 176
Provider WLMH NHS T

Brent
Population 245,574
EIP caseload 231
Provider CNWL NHS FT

Camden and Islington
Population 365,663
EIP caseload 458
Provider CANDI NHS FT

City and Hackney
Population 201,452
EIP caseload 137
Provider EL NHS FT

Tower Hamlets
Population 203,811
EIP caseload 144
Provider EL NHS FT

Hounslow
Population 203,766
EIP caseload 126
Provider WLMH NHS T

Hammersmith and Fulham
Population 147,262
EIP caseload 108
Provider WLMH NHS T

Kensington, Chelsea & Westminster
Population 314,033
EIP caseload 205
Provider CNWL NHS FT

Richmond upon Thames
Population 135,973
EIP caseload 69
Provider SWLSG MH NHS T

Kingston upon Thames
Population 133,448
EIP caseload 63
Provider SWLSG MH NHS T

Lambeth
Population 274,093
EIP caseload 188
Provider SLAM NHS FT

Southwark
Population 219,558
EIP caseload 193
Provider SLAM NHS FT

Greenwich
Population 184,852
EIP caseload 82
Provider Oxleas NHS FT

Wandsworth
Population 274,424
EIP caseload 167
Provider SWLSG MH NHS T

Lewisham
Population 207,990
EIP caseload 181
Provider SLAM NHS FT

Bexley
Population 141,138
EIP caseload 76
Provider Oxleas NHS FT

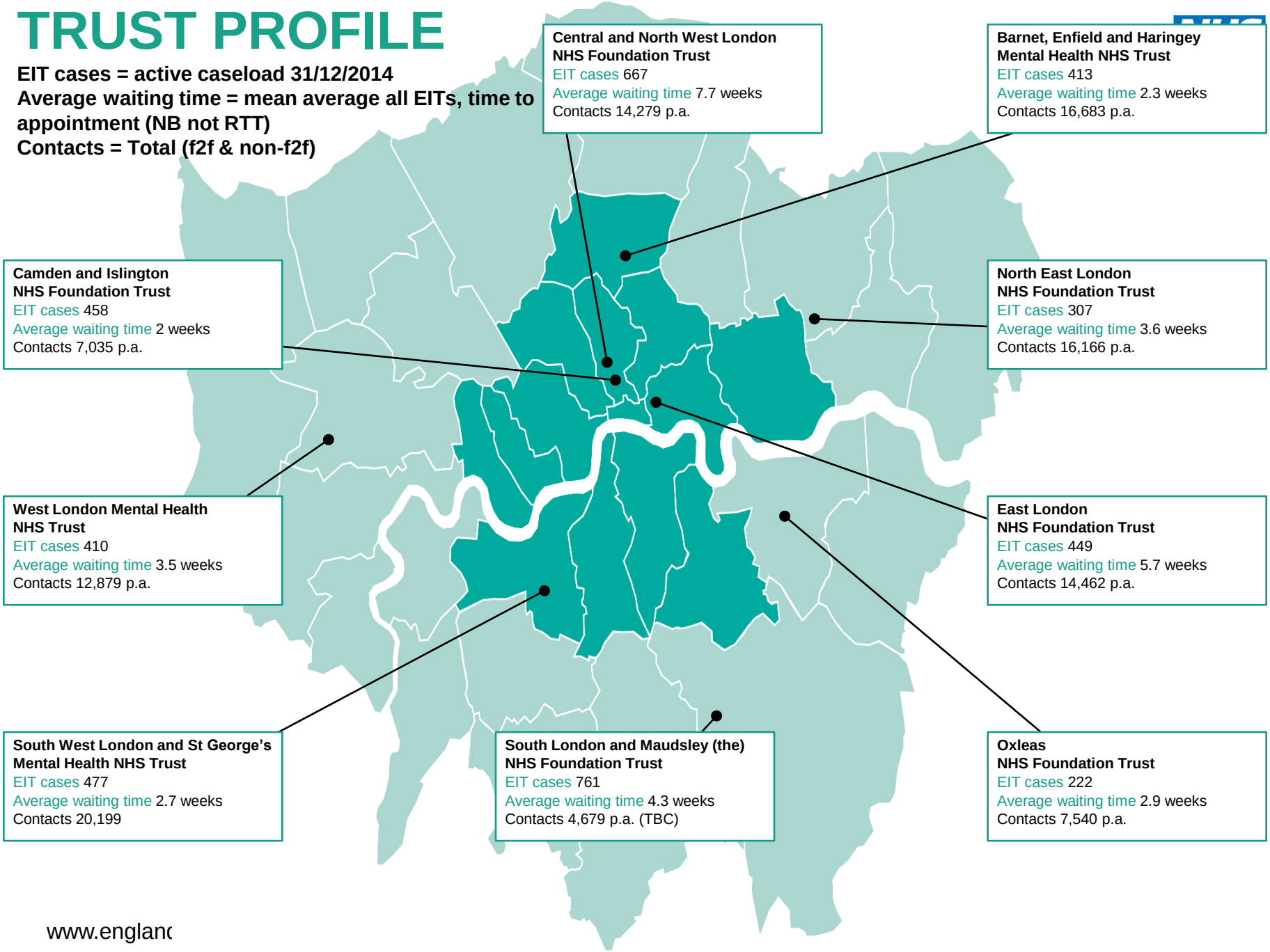
Sutton and Merton
Population 267,412
EIP caseload 178
Provider SWLSG MH NHS T

Croydon
Population 256,804
EIP caseload 199
Provider SLAM NHS FT

Bromley
Population 209,745
EIP caseload 64
Provider Oxleas NHS FT

TRUST PROFILE

EIT cases = active caseload 31/12/2014
Average waiting time = mean average all EITs, time to appointment (NB not RTT)
Contacts = Total (f2f & non-f2f)



Central and North West London NHS Foundation Trust
EIT cases 667
Average waiting time 7.7 weeks
Contacts 14,279 p.a.

Barnet, Enfield and Haringey Mental Health NHS Trust
EIT cases 413
Average waiting time 2.3 weeks
Contacts 16,683 p.a.

Camden and Islington NHS Foundation Trust
EIT cases 458
Average waiting time 2 weeks
Contacts 7,035 p.a.

North East London NHS Foundation Trust
EIT cases 307
Average waiting time 3.6 weeks
Contacts 16,166 p.a.

West London Mental Health NHS Trust
EIT cases 410
Average waiting time 3.5 weeks
Contacts 12,879 p.a.

East London NHS Foundation Trust
EIT cases 449
Average waiting time 5.7 weeks
Contacts 14,462 p.a.

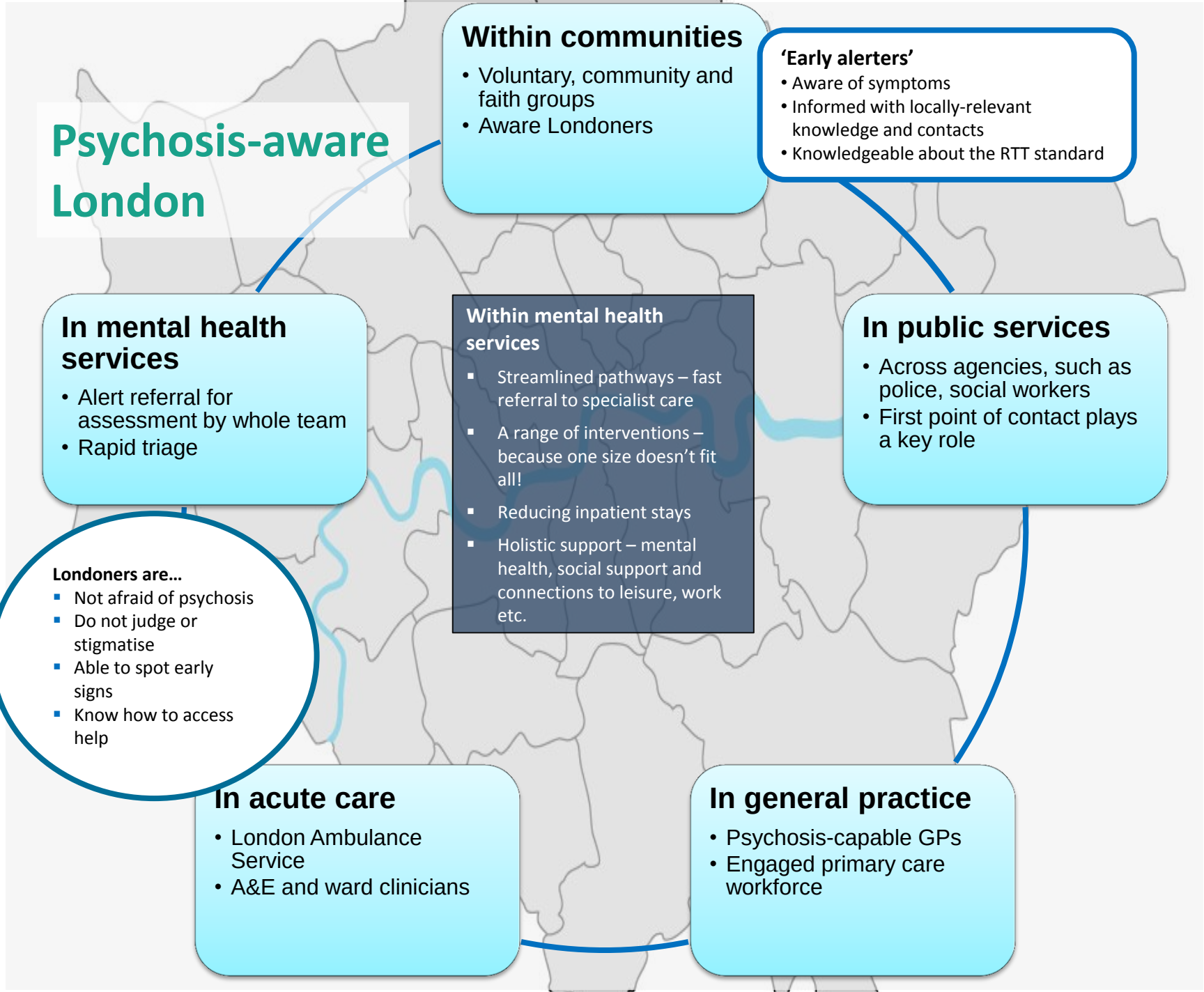
South West London and St George's Mental Health NHS Trust
EIT cases 477
Average waiting time 2.7 weeks
Contacts 20,199

South London and Maudsley (the) NHS Foundation Trust
EIT cases 761
Average waiting time 4.3 weeks
Contacts 4,679 p.a. (TBC)

Oxleas NHS Foundation Trust
EIT cases 222
Average waiting time 2.9 weeks
Contacts 7,540 p.a.

ADDITONAL PRIORITIES FOR CRG

- OPTIMISING THE CARE PATHWAY - BEST ROUTES
- THE WORFORCE TRAINING AND DEVELOPMENT
- Best clinical practice guidance - IMPORTANTLY THE USE OF MEDICATION


Psychosis-aware London
Within communities
• Voluntary, community and faith groups
• Aware Londoners
'Early alerters'
• Aware of symptoms
• Informed with locally-relevant knowledge and contacts
• Knowledgeable about the RTT standard
In mental health services
• Alert referral for assessment by whole team
• Rapid triage
Within mental health services
▪ Streamlined pathways – fast referral to specialist care
▪ A range of interventions – because one size doesn't fit all!
▪ Reducing inpatient stays
▪ Holistic support – mental health, social support and connections to leisure, work etc.
In public services
• Across agencies, such as police, social workers
• First point of contact plays a key role
Londoners are…
▪ Not afraid of psychosis
▪ Do not judge or stigmatise
▪ Able to spot early signs
▪ Know how to access help
In acute care
• London Ambulance Service
• A&E and ward clinicians
In general practice
• Psychosis-capable GPs
• Engaged primary care workforce

KEY FINDINGS(1)

Headlines

- **Overall, strong 'in principle' support** from London residents for the introduction for a referral to treatment target and the key aims of the EIP programme
- (Understandably) "psychosis" as a term and diagnosis is **not well-understood** by the public
- However, the public in London is in **relatively good shape**
  - to spot the symptoms and behaviours which should prompt them to seek help
  - With a good understanding of the right agencies to turn to.

KEY FINDINGS (2)

Messages for public-facing communication

- **We should segment the London public**. Clear differences between:
  - Men and women
  - Older and younger people (possible mid-thirties transition)
  - Young people aged 16-24, who both hold different views and are in the age cohort most likely to experience first episode psychosis
- **Leading with the term "psychosis" is not likely to be effective** - the focus should be on symptoms/behaviours and next steps to take.
- **Information about when and how they should seek help** should be clear and definitive - especially about 'first ports of call', ideally standardised across London
- An important objective of public guidance should be to raise the general level of understanding and confidence:
  - **Positive** messages about outcomes and recovery
  - **Reassurance** that an effective range of services is available

READINESS TOOL

a self-diagnostic tool for trusts

Together with the national IMAS team and colleagues at Oxleas NHS Foundation Trust, we have created a diagnostic tool for trusts to help them prepare for the new EIP standards. Based on the readiness tool prepared for the cancer RTT programme, the tool guides trusts through issues such as reporting measures, staff capacity, leadership and governance. A member of the EIP London programme will work with trusts to assist them in using this self-diagnostic assessment tool.

WHAT NEXT

- EXAM QUESTION – demand and capacity
- Continue the engagement via preparedness tool
- Work with referrers GPs and other internal secondary providers
- Technical Preparation - Jade, RiO, CareNotes and EPJS readiness
- Shadow Go Live Prep for 1st November – use of ‘simple form’ – best way of learning from each other?
- Financial risk assessment?
- Training needs….course content….releasing staff
  - Family therapy now
  - CBT for psychosis in medium term
- A social marketing plan? Influencing help-seeking?
- Good practice guidance
- Communication, Communication, Communication

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www.londonscn.nhs.uk

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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