GETTING IT RIGHT FIRST TIME

# Mental Health – Adult Crisis and Acute Care

## GIRFT Programme National Specialty Report

**By Dr Ian Davidson**
GIRFT Clinical Lead

**April 2021**

GIRFT is delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust, NHS England and NHS Improvement

# Contents

# Foreword

This review of adult crisis and acute mental health care led by Dr Ian Davidson comes at a time when ensuring that people have access to effective and efficient mental health services is more important than ever, due to the experiences of people living through the COVID-19 pandemic.

One in four adults experiences a mental health problem in any given year, and demand for adult mental health services is predicted to rise significantly in the near future, driven by the experiences of lockdown. Conditions such as post-traumatic stress disorder (PTSD), anxiety and depression could be prevalent for months or years to come. This adds further significance to the recommendations in this report giving many of them a greater sense of urgency.

Actions in this report, such as maximising capacity with a 24/7 crisis line to deliver virtual and face-to-face contacts in the community, can help the NHS as it faces the substantial challenge of coping with this increase in demand for mental health care in the context of COVID-19.

The recommendations in this report are based on the virtual visits that Dr Davidson made to mental health trusts across England, in addition to other data and audits. Implementing these recommendations will help people to gain equitable access to timely and effective mental health care and treatment before their need becomes an emergency.

The recommendations in the report are also vital to ensure people do not get stranded in the wrong part of the crisis pathway, but instead have an easy route in and out of mental health services when needed.

There is also a need for more consistent data and data reporting in the service, especially on outcome measures. Without this, efforts to improve services and provide patients with suitable care when they need it can be hampered, so it is our hope that this report will lead to more routine analysis and reporting of outcome data to drive further improvements.

It has been encouraging to hear about the enthusiasm and innovation that Dr Davidson has seen as he has met with colleagues on deep-dive visits. There were many examples of excellent practice, some of which are included as case studies in this report. These are testament to the hard work and dedication of everyone working in the specialty.

Such dedication is vital to the GIRFT programme, which can only succeed with the backing of clinicians, managers and everyone involved in delivering care.

The intention is that GIRFT will provide support and impetus to enable all those involved in mental health crisis and acute care to work shoulder to shoulder and continue making a real difference to peoples' lives.

### Professor Tim Briggs *CBE*

***GIRFT Programme Chair and National Director of Clinical Improvement for the NHS***

*Professor Tim Briggs is a consultant orthopaedic surgeon at the Royal National Orthopaedic Hospital NHS Trust, where he is also Director of Strategy and External Affairs. He led the first review of orthopaedic surgery that became the pilot for the GIRFT programme, which he now chairs. Professor Briggs is also National Director of Clinical Improvement for the NHS.*

### Professor Tim Kendall

***National Clinical Director for Mental Health for the NHS***

*Professor Tim Kendall is National Clinical Director for Mental Health for the NHS. He is also Director of the National Collaborating Centre at Royal College of Psychiatrists and University College London (UCL) where he is visiting professor. He is a consultant psychiatrist for homeless people in Sheffield.*

# Introduction from Dr Ian Davidson

There is a long tradition of benchmarking in mental health services. One of the earliest attempts, a 1500-page study published in 1887 called Lunacy in Many Lands, which was perhaps even more ambitious than the Getting It Right First Time programme, attempted to survey and benchmark individual asylum facilities in many countries across the world, including England. Incredibly, the book highlights many of the same themes revealed in this report (including variation in areas such as staffing mix, cost per patient and the use of restrictive practices). Reassuringly, there is also clear evidence of progress on many issues.

Mental health services in England vary in terms of size and geography covered, the range of services they provide, and the mix of patients that they serve. As such, some variation is to be expected. But not all variation is warranted, and some may be detrimental to the needs of individuals and communities. The aim of the GIRFT programme is to uncover and find ways to eliminate this unwarranted variation. Hearteningly, in our visits to trusts we saw great agreement on which issues are important, pushing us more certainly towards developing actionable steps in defined core areas.

One key issue – a topic that cuts across all areas of this report – involves issues with how we collect, manage and make use of information. Although vast amounts of data are recorded within mental health services, their collection and use tend to be marked by inconsistencies and inefficiencies. This leaves clinicians, trusts and administrators hamstrung in attempts to assess and plan services and ensure that patients receive timely, equitable and effective care. If we can improve our use of data, much of the unwarranted variation highlighted in our findings will become far easier to eliminate.

Alongside longstanding challenges, looming over our work on this report was the sudden arrival of COVID-19. The impact of the pandemic on peoples' lives has already shown itself to be all-encompassing. Just as mental health problems do, COVID-19 will disproportionately impact the poorest and most vulnerable of society, exacerbating inequality and giving rise to new and worsened cases of mental illness. One of the biggest challenges facing mental health services will be to work out how best to deliver high standards of care as demand rises and funding across the whole system becomes scarcer.

But one route out of a critical impasse is through innovation. If some benefits are to be gleaned from the COVID-19 outbreak, they may lie in the development of more efficient practices, new ways of working and new ways of accessing care. Steps forward have already been made in response: in March 2020, for example, with providers confronted by the impact on mental health of the pandemic, a target to implement a 24-hour mental health crisis access service was implemented a year ahead of schedule.

This report has been developed at a time when the ways in which we operate have been brought firmly into the spotlight. We have a valuable opportunity to answer some important questions: are individual resources being consistently directed to where the need is highest? Are services being delivered in ways that are timely, accessible, effective and sustainable for those who need them, while also being meaningful to every individual in a community?

The existence of both new challenges and some that are common to those faced 130 years ago should not be disheartening. Today, more people in England are able to access community-based mental health services than ever before. And despite the challenges that providers face, overall satisfaction with services remains high. Every trust that we visited showed us examples of good practice and how they are working to innovate, apply best-practice evidence and identify the best ways of using available resources to meet the needs of local communities.

But the availability of resources does place a ceiling on what can be achieved, no matter how efficiently or effectively care is delivered. Services consistently operating at or beyond capacity are likely to see more gaps and more mistakes being made, hence the importance of properly funding mental health care. The increased funding for mental health services in the NHS Long Term Plan and the Mental Health Investment Standard is therefore welcome. We have a valuable opportunity to tackle both longstanding and more recent challenges head on and to build on the vast amount of good work already being done every day.


## Dr Ian Davidson

*GIRFT Clinical Lead for Mental Health Adult Crisis and Acute Care*

*Dr Ian Davidson is a consultant general adult psychiatrist at Cheshire and Wirral Partnership NHS Foundation Trust with extensive experience of community and inpatient general psychiatry. He has been a medical director, deputy chief executive and interim chief executive and is currently clinical quality lead for the trust.*

# Statements of support

## The Royal College of Psychiatrists

The College very much endorses the Getting It Right First Time programme and has very much appreciated the opportunity to input into this report on such an important issue affecting mental health.

Acute and crisis care in mental health is where those in most severe need will present for care, and it is crucial that they are both able to access it in a timely fashion and receive the best evidence-based care possible. This report highlights clearly and helpfully not just some of the existing challenges, but also some of the solutions that could drive real progress.

These are solutions that both national and local NHS structures need to deliver, both in terms of the fulfilment of the promises in the Long Term Plan on the necessary financial and workforce resources at a national level, and developing a better understanding and acting upon of the level of demand at a local level.

The College will do all it can to support the effective implementation of the recommendations from this report

**Dr Adrian James**
*President*

# Statements of support

## The Care Quality Commission

On behalf of the CQC, I welcome this report from the Getting It Right First Time programme and fully support the recommendations made to improve patient care for those accessing adult crisis and acute mental health care. A number of the findings and recommendations are echoed in our own work, and we are pleased to see these prioritised to ensure people are able to access safe and quality mental health care when they need it. In particular these include:

- timely access to appropriate mental health services and multi-disciplinary teams to meet the ongoing demand for adult mental health care;
- adequately trained and appropriately skilled individuals and multi-disciplinary teams able to provide adult mental health care whenever it is needed;
- NHS Mental Health trusts enabled to identify, improve and sustain mental health care provision via relevant adult mental health care service pathways in the most suitable environments;
- the collection, analysis and effective use of data related to mental health care demand, capacity and flow on a national basis to deliver more targeted outcomes;
- the need to fully recognise and ensure NHS mental health trust providers work with system-wide partners – NHS mental health trusts alone cannot deliver all of this report's recommendations.

The COVID-19 coronavirus pandemic has severely impacted all healthcare in England in 2020, including the current provision of NHS mental health services and will continue to have a longer-term effect on the safe, high-quality care provision of all adult mental health services. During this period, CQC monitoring will have clear areas of focus specifically targeting safety, access to services and leadership. Our regulatory focus will continue to be on services where we have concerns about care, and we will continue to take appropriate action to protect people from harm and abuse if necessary.

**Dr Kevin Cleary**

*Deputy Chief Inspector for Hospitals and Lead for Mental Health and Community Services*

# Executive summary

One in four adults experiences at least one diagnosable mental health problem each year, and mental illness costs the UK economy £105bn annually.[1,2] In 2018/19 more than 3.2 million people in England accessed the Improving Access to Psychological Therapies (IAPT) programme and serious mental illness (SMI) services.

## The context: supporting core community services in the face of new challenges

Although acute and crisis mental health services have traditionally been discussed in terms of inpatient treatment, NHS mental health care today is an overwhelmingly community-based service – according to the NHS Benchmarking Network (NHSBN), only 6% of those accessing SMI services in 2018/19 received inpatient care. A relatively recent reorientation of community mental health services has reflected this, in the process easing some of the entrenched pressure on core community services. However, community-based services remain underequipped and in need of greater funding. At the same time, timely and effective inpatient care should be accessible locally and rapidly when it is essential.

The development and funding of mental health crisis and acute care is currently tied to the NHS Long Term Plan (LTP), which sets a range of provisions and targets to be reached by 2023/24. There is a welcome focus in the commitments of the NHS LTP to service expansion and ensuring timely access to core community and crisis mental health services. This is the heart of the current challenge facing providers of adult mental health crisis and acute care.

### Timely, equitable access is essential

Timely access to mental health care is vital to ensuring that patients receive care that is optimal to their needs. In many cases, the more time that passes before treatment is accessed, the greater the likelihood that a condition will become more chronic and difficult to treat, and the greater the risk of secondary or tertiary disabilities.

Certain social and demographic factors increase vulnerability to mental health problems and hinder timely access to care. Among those affected are people living in deprivation or poverty; older people; people with dementia; combat veterans; people with learning disabilities and autistic people; Black, Asian and minority ethnic people; and people with substance misuse problems. It is also likely that the COVID-19 pandemic has not only increased overall demand, but also disproportionately worsened the mental health burden for the most vulnerable.

### System-wide challenges require system-wide solutions

A key overarching part of implementing the recommendations and good practice contained within this report will involve acknowledging the linkages and dependencies between all levels of NHS mental health care and the constituent parts of the wider health and social care system; all of these impact the capacity to prevent SMI and achieve positive outcomes for those affected by SMI. Put simply, getting it right first time at each step reduces the numbers likely to need more intensive levels of care. In turn, this reduces the number of people requiring treatment at each step, thus facilitating better use of capacity to deliver effective interventions.

Well-managed flow between different services and different levels of care is a key part of this. Stepping up and stepping down the intensity of care when appropriate, as well as ensuring that access to care operates on an easy-in, easy-out basis, means that fewer people will be stranded in the wrong part of the pathway (or outside of services) at any given time. Addressing mental health issues in this way reduces the risk of people reaching severe or crisis state before they can access appropriate help, as well as reducing the number of people needing inpatient admission.

For those who do reach crisis state, whether requiring intensive home or community-based treatment or inpatient admission, the same principles apply. Patients should receive an appropriate level and intensity of care in a timely manner. Such care should be delivered in ways that are shown to be the most effective, making the best use of available resources and the most up to date evidence.

Trust boards have a unique opportunity to contribute to oversight of this whole pathway, and they must ensure that their dashboards give them appropriate, high-quality data. This will allow them to have a firm grasp on the whole care pathway, allowing them to identify where problems might be occurring – and where opportunities exist to further improve local services.

[1] *NHS England, 2020. Adult and older adult mental health. www.england.nhs.uk/mental-health/adults/.*

[2] *Public Health England, 2018. Reducing health inequalities in mental illness. www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness*

Beyond core NHS services, mental health care in England is a collaborative effort. In concert with NHS services, key roles are played by a range of system partners in supporting mental health crisis and acute care. These include (but are not limited to) primary care services; specialist physical health services; local authorities; police and other emergency services; and the voluntary, community and social-enterprise sector. Although the work of these partners is out of the scope of this report, their contributions are vital.

## Key domains

To frame our assessment, we have taken an end-to-end view that mirrors both the journeys taken by individual patients and the overall context in which mental health crisis and acute services are provided. Reflecting this approach, the core of this report is structured around four key domains:

- Demand
- Capacity
- Flow
- Outcomes

Overarching all four of these areas is a focus on the gathering, reporting and use of data – an all-encompassing issue that poses major challenges to the provision and improvement of mental health crisis and acute care.

## Our findings

### Data: an all-encompassing issue

- A major overarching difficulty we faced in conducting our analysis was inconsistency in data quality and reporting, including the extremely limited use of outcome measures. This is a major factor behind unwarranted variation across mental health services.
- Although a vast amount of data is recorded, its collection and processing tends to be inconsistent and inefficient, hindering attempts to assess the effectiveness of services and plan for the future.
- Poor data practices can create a misleading picture, in turn hampering strides to improve services and provide patients with the care that is most suitable to them when they need it.
- Key to solving these issues is the proper segmentation of data. A move beyond trust- and national-level averages will help to target resources and interventions in ways that provide the best value and are inclusive of the whole population being served, including vulnerable and otherwise excluded populations.

### Demand

- There is huge variation in geography, social context and demographics (and the recording of these factors) between and within trusts. For example, trust-by-trust variation in the proportion of patients categorised as coming from BAME backgrounds varies from 3.3% to 67.8%. Only 43% of trusts operate systematic measures to identify barriers to provision for underrepresented groups.
- Assessment of unmet demand is complicated by a lack of specific data. A combination of robust data on referrals, acceptance and did-not-attend (DNA) rates for new referrals would give a clearer picture of unmet demand. At present, there is significant variance between trusts in both acceptance and DNA rates.
- Patient data should be segmented – for example, trusts should move away from viewing BAME people as a single group – and combined with local knowledge, so that service planning can become a more bespoke service. At present, high-level data are often aggregated, which limits how much knowledge can be gleaned from what is being reported.
- The use of clinical coding would provide a fuller picture covering treatment, diagnosis, complications and comorbidities. Access to such data, properly reported and analysed, would offer true benefits in terms of service planning.
- Improvements must be made to ease data sharing. This will make for a more cohesive treatment journey. In addition, trusts and providers will be better equipped to assess local population health and plan services accordingly.

- It is likely that the COVID-19 pandemic will be responsible for both short and longer-term increases in demand. Already vulnerable populations are likely to be disproportionately affected by the mental health impacts arising from the pandemic, and surges of COVID-19 are likely to worsen the impact on mental health.
- Remote outreach and screening will help to assess the mental health burden of COVID-19, as well as bringing extra patients into the service. However, close attention should be paid to potential inequalities to access created by remote outreach.

## Capacity

- Core community contacts and caseloads declined per 100,000 population between 2014 and 2019. Partly this is related to the reorientation of services (including the expansion of IAPT and specialist services such as liaison psychiatry). However, core services remain stretched and in need of increased funding.
- Although only 6% of the 1.6 million people accessing severe mental illness (SMI) care per year receive inpatient treatment, about half of trusts still invest more in inpatient care than community services, partly reflecting the higher costs associated with inpatient services.
- Costs per patient vary greatly between trusts. Although there are issues with data quality, and some variation is warranted, lower costs tend to be associated with lower skill mix and higher caseloads, which makes providing optimum care and treatment more difficult.
- Upwards of 60% of referrals to Community Mental Health Teams (CMHTs) are rejected by a small number of trusts. We suggest that serious systemic issues are indicated when more than 10% of referrals are not being accepted.
- Although the NHS LTP mandates the ending of out of area placements (OAPs) by March 2021, their numbers remain high in some trusts. In 2018/19 the range of out of area bed usage by trusts varied enormously, with some having zero or very few OAPs while some reported more than 100. Overall, 8.5% of total inpatient admissions resulted in OAPs.
- Overall mental health workforce numbers began to increase in 2017 after a sustained decline. However, there are concerns that staffing will not be able to match increases in demand. There is wide variation in recruitment and retention, as well as high usage of bank and agency staff.
- There are questions over how the workforce is utilised. For example, over 50% of Getting It Right First Time (GIRFT) survey respondents said that it takes clinicians over an hour to input an assessment into an electronic health record. This varied greatly between trusts, from less than 30 minutes to over 90. There are also issues with how data is recorded and used for workforce planning.
- The response to COVID-19 has accelerated moves to meet capacity-related targets. For example, plans to establish 24-hour access to a crisis line from March 2021 were met in April 2020. The challenge is to make sure that changes to services are sustainable.

## Flow

- GIRFT survey responses showed variation in the sharing of assessments with patients, something that is vital to eliminating inaccuracies and subsequent delays. In 43% of trusts assessments are shared with less than 20% of patients. A quarter of trusts said that assessments are always shared.
- There is no routinely available data on which treatments people receive in community care, leading to a reliance on sources such as Early Intervention in Psychosis (EIP) survey data and patients' notes to assess use and variation of interventions. The available data demonstrates huge variation on uptake of NICE-recommended interventions, a target of improvement in the NHS LTP.
- Crisis Resolution and Home Treatment (CRHT) teams are best placed to decide which cases can be best treated in the community and should also act as gatekeepers to inpatient admission and discharge. However, in 2018/19 inpatient admissions were the sole responsibility of CRHT teams in only 58.2% of trusts.
- Admissions that lack a defined purpose tend to last longer and be less successful. For admission to be truly purposive, trusts must measure success of achieving that purpose at discharge. Although around 89% of trusts capture purpose of admission, only just over a third measure success of achieving that purpose at discharge.
- Data demonstrate significant A&E attendance in the hours before acute mental health inpatient admission, suggesting that there is work to be done before A&E presentations can be limited to essential need. There is also a lack of systematic data in relation to which patients go to A&E or use liaison services.

- There is wide variation in the percentage of people admitted under the Mental Health Act 1983 (MHA). Although a variety of possible explanations have been put forward for this in the literature and in GIRFT deep dives, much of this variance is unexplainable with available data.
- Acute inpatient length of stay was 60 days or above in about 15% of cases in 2018/19, implying at least some inefficiency in flow between different areas of care. Short stays also need to be monitored, as they may imply unnecessary inpatient admission. About 15% of inpatient admissions in 2018/19 resulted in hospital stays of 0–3 days.
- There is wide variation in reporting of mental health and the impact of co-occurring conditions. For example, the GIRFT survey found that only a minority of trusts collect and review access and outcomes data for patients with autism and learning disabilities in mental health services.
- A lack of coding in mental health services makes it very difficult to report or analyse any routine data on quantity and impact of co-occurring conditions and/or social risk factors.
- Regular patient reviews are needed to ensure optimal care is provided during COVID-19. This is particularly important for people with SMI, who may be more marginalised during the pandemic. Initial evidence suggests that where community contacts have fallen people are more likely to present in worse states and at later stages of crisis, leading to higher rates of inpatient admission, including under the MHA.

## Outcomes

- There are a lack of routine outcome measures in most areas of mental health, and there are major reporting gaps in areas such as diagnostic coding, primary diagnosis and intervention. The mean level of primary diagnosis recording in 2018/19 was 21.9%; this varied from above 60% to close to zero.
- The pairing of admission and discharge data (which is vital to measuring outcomes) is rare. Average paired measurement rates in reporting using the Health of the Nation Outcome Scale (HoNOS) are 33% for EIP, and 28% for both CRHTs and inpatient services. This means that outcomes cannot be identified in the majority of cases.
- There is wide variation in the recording and availability of patient experience data in mental health services in England. In addition, the majority of measures are based on small samples rather than routine reporting.
- In addition to inconsistencies in patient-centred practices and the use of patient experience measures, trusts tend to record negative outcomes, but not positive ones. For example, although considerable data is available on restrictive practices, some trusts do not routinely record compliments.
- The use of restrictive practices varies hugely across providers. In particular, there is huge variation in the use of restraint and prone restraint that is not explainable with current data.

# Recommendations

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **1.** Each ICS/STP area should ensure that it understands the needs of the local community and the demand for mental health services, employing Joint Strategic Needs Assessment (JSNA) where appropriate. | **a** Trusts to review local population needs assessments such as JSNA and to take into account factors known to increase mental health needs and demand, including but not limited to the vulnerable groups highlighted in the report to help drive their strategic plans between 2022-2025. | Trusts with support from GIRFT, ICS/STPs, and NHS England and NHS Improvement | For progress within 12 months of publication |
| | **b** Services commissioned to accurately reflect local needs (not just existing demand) to ensure these groups are not being doubly disadvantaged. | | |
| | **c** Trusts to ensure data is segmented to take account of variation in local area needs. | | |
| | **d** Trusts need to work with commissioners to ensure clear information is provided about what is available for local communities, and this is shared and taken into account when estimating demand for trust-provided SMI services. | | |
| | **e** Trusts to co-produce all service developments,and redesigns with those who will access such services, will help deliver those services and those affected by those services. | | |
| **2.** Trusts need to work with system partners to ensure that it is clear which needs IAPT services have been commissioned to meet locally. | **a** Ensure that all planning of SMI services takes into account IAPT-commissioned deliverables, outcomes and prevalence. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |
| | **b** Ensure that IAPT services are delivered in line with the IAPT manual, and with NICE guidance on psychological therapies. | | |
| **3.** Trusts need to work with system partners to understand and mitigate increased demand on SMI services related to COVID-19. | **a** Ensure the sustainability of new and/or modified practices such as rollout of 24/7 access lines, and wider use of remote working models and technology established during COVID-19 to improve or assist use of available capacity. | Trusts with support from GIRFT, ICS/STPs, NHS England and Improvement | For progress within 12 months of publication |
| | **b** 24/7 crisis lines to link in to 111 telephone services. | | |
| | **c** Trusts to work with their ICS/PCN and with the relevant national bodies as partners to understand and mitigate the impact of COVID-19 on SMI services. | | |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **4.** Trusts must ensure that the aims of the NHS LTP Mental Health Implementation Plan and LTP transformation funding are met locally. | **a** All trusts to work with system partners to ensure that the Mental Health Investment Standard is met locally, and that they have nominated finance/transformation leads at senior level with a thorough understanding of the Standard, and can specifically identify the growth in investment expected in each service area between 2018/19-2023/24, and works with ICS/CCGs to ensure the trust receives its share of investment in line with that growth. And to regularly report at board and ICS and STP level on the success of implementing the requirements set out in the NHS LTP Mental Health Implementation Plan.<br>**b** Trusts to contribute to new NHS England and NHS Improvement national financial planning process to allow triangulation between CCG stated growth in mental health investment and mental health trust income (and, where necessary, reconciliation between the two). | Trusts with support from GIRFT, ICS/STPs, CCGs, NHS England and Improvement | For progress within 12 months of publication |
| **5.** Trusts need to work with partners locally and through national bodies to establish and train sufficient numbers of professionally qualified staff – including nursing and medical staff, allied health professionals (AHPs), and clinical psychology, pharmacy and social work staff – to meet the patient need for SMI services in England. Trusts also need to reduce vacancy rates and the reliance on agency and locum staff. | **a** Key national bodies to ensure that there are adequate numbers of undergraduate and postgraduate training opportunities to meet trust-level workforce demand.<br>**b** Trusts to identify gaps in being able to recruit and retain staff with the necessary qualifications to fill key roles currently and in relation to future development of services to work with partners, including but not limited to Health Education England, to map demand and capacity for future workforce so that supply meets future need. | Trusts with support from GIRFT, ICS/STPs, NHS England and Improvement, Health Education England, Royal College of Psychiatry | For progress within 12 months of publication |
| **6.** Trusts need to carry out regular ongoing consideration of opportunities to improve skill mix and evaluation of the impact of any changes or innovations. Such opportunities might include increasing the numbers of peer support workers and professionally qualified staff, including nursing, medical, AHP, clinical psychology, pharmacy and social work staff, and increasing the range of posts such as physician or nurse associates, to further develop new roles (both professionally qualified and non-professionally qualified) and models of care delivery. | **a** Trusts to routinely consider skill mix in any workforce reviews or developments, such as the national projects referenced in the NHS LTP Mental Health Implementation Plan, to be based on local needs assessments, including JSNA and the best available evidence. | Trusts with support from GIRFT, ICS/STPs, Royal College of Psychiatry | For progress within 12 months of publication |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **7.** Trusts need to ensure that existing staff capacity is efficiently utilised and clinician time used to best effect; trusts also need to look at staff wellbeing and support. | **a** Trusts to consider implementation of voice dictation software for data entry. | Trusts with support from GIRFT, Health Education England, | For progress within 12 months of publication |
| | **b** Trusts to improve the IT infrastructure and functionality of systems for timely input and retrieval of information. | | |
| | **c** Trusts to review use of staff time (particularly professionally qualified staff), and clearly outline expectations and deliverables in terms of time management in clinical practice to make best use of professional skills. | | |
| | **d** Trusts to ensure that opportunities are seized from developing the framework for core digital capabilities in mental health services, building on work underway e.g. as described in the Topol Review. | | |
| **8.** Trusts need to ensure that their systems are not routinely running at or very near maximum capacity in order to reduce staff burnout and risk of errors, give sufficient flexibility to deal with surges in demand, and allow system thinking and review time. | **a** Trusts to ensure that average inpatient bed occupancy rates are no more than 85% in line with Royal College guidelines. | Trusts with support from GIRFT, ICS/STPs, Commissioners | For progress within 12 months of publication |
| | **b** Trusts to work on optimising patient flow using tools such as the Red2Green approach. | | |
| | **c** Trusts to work with system partners, including commissioners, to be clear how much capacity has been commissioned for each locality, and how much of the expected demand for SMI services can feasibly be met. | | |
| | **d** Trusts to ensure that there is clarity from commissioners for people whose needs do not reach the threshold for the commissioned capacity in the SMI service and for local community and primary care staff, as to what is locally available for them. | | |
| | **e** Ensure that non-human capacity (such as inpatient accommodation, information systems, team bases and clinical facilities) is fit for purpose and adequate capital investment is available to modernise outdated facilities. | | |
| | **f** Trusts with commissioners to report on all NHS funded acute/PICU bed usage for that area, whether it is being provided by trust-based beds, or other providers (in and out of local area), so that total capacity and usage is routinely visible in board reports. | | |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **9.** Trusts need to use routinely collected data to explore unexplained variation in reception and acceptance of referrals. | **a** Trusts to establish and maintain robust systems for measuring demand (referrals received) and supply (referrals accepted into treatment).<br>**b** Trusts to include timely analysis (as part of the board quality dashboard) of where variance occurs – i.e. more referrals received than accepted or first point of contact is not through Route 1 – alongside an explanation and any necessary contingent actions.<br>**c** Trusts to segment data on referrals (received and accepted) to identify if any groups in the local community are under or over-represented at any entry point, and to report on this to trust board and system partners.<br>**d** Trust to flag any identified issues in ICS/STP and PCN discussions. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |
| **10.** Trusts need to engage with patients and carers to identify and reduce avoidable barriers to patient access to SMI services, as well as ensuring that they have fast-track access to CMHTs and other recognised best practices for referral and patient pathway routes. | Examples include:<br>**a** Trusts to provide access options such as email, text and video consultations, and other digital solutions for service users for whom telephone access is a barrier.<br>**b** Trusts to provide clear information on referral and access routes on the trust public website for each service.<br>**c** Trusts to work with local communities to ensure that potential barriers to access for any part of the community are identified and addressed to reduce inequity of service.<br>**d** Ensure that the national standards on accessible information are met. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |
| **11.** Trusts need to monitor, analyse and report on step-up in intensity of services to ensure that step-up is essential, timely and equitable. | **a** Trusts to use established techniques such as (but not limited to) the following:<br>• Capture the purpose of step-up<br>• Step-up when essential, not as a last resort<br>• Use of Red2Green or similar flow improvement methodology<br>• Patient-initiated follow-up.<br>**b** Trusts to establish clear systems for timely step down when purpose of step-up has been achieved.<br>**c** Trusts to capture and use information on system step-up issues such as high rates of section 136, high rates of section 2, high rates of first contact with SMI services or inpatient admission via A&E in discussions with ICS/PCNs to reduce high rates.<br>**d** Trusts to use robust sustainable models for 24/7 access.<br>**e** Trusts to regularly review factors that could potentially impact flow to ensure that people do not become stranded in community teams or inpatient services.<br>**f** Trusts to ensure that trusts services are routinely using evidence-based ways of reducing DNA and no-contact rates. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **12.** Trusts need to ensure that person-centred care and co-production of care plans is standard (including to the maximum extent feasible within the law for those detained under the MHA).<br>For people who lack capacity, care planning should follow the principles and rules set out in the Mental Capacity Act. | **a** Trusts to ensure the electronic health record clearly highlights any documents provided by the person to support reviews and/or contacts (e.g. advance directives, hospital passports).<br>**b** Trusts to ensure all assessments and formulations are routinely shared with the person in a timely manner to allow for clarification or correction of any factual errors.<br>**c** Trusts to select the contact method – face-to-face, video link, telephone, text or email – most suitable for delivering the most appropriate intervention, taking into account each person's needs and wishes.<br>**d** Trusts to reduce duplicate assessments by recording once and using often by having timely access when needed to information entered by any team.<br>**e** Trusts to ensure that all of the above are part of the board quality review.<br>**f** Trusts to develop crisis plans as part of care plans in line with NICE guidance. | Trusts with support from GIRFT | For progress within 12 months of publication |
| **13.** Trusts need to record robust, publicly available outcome and intervention data, and share this with partners and people accessing services as appropriate – in the process meeting (but not being limited to) regulatory requirements. | **a** Trusts to commit to recording and reporting outcomes consistently for all patients including – as a minimum at least one clinician rated outcome measure such as paired HoNOS scores.<br>**b** Trusts to routinely record and share patient outcome measures such as DIALOG with a view to linking this into work already underway in relation to the LTP Mental Health Implementation Plan.<br>**c** Trusts to link outcomes with interventions delivered – this requires robust recording and reporting systems that do not reduce clinical capacity by taking significant clinical time to input – using the move to SNOMED CT to help drive this.<br>**d** MHSDS and Model Hospital to be the repository for key data to reduce numbers of ad hoc information requests, and ensure ability for robust benchmarking to help drive quality improvement at all levels. | Trusts with support from GIRFT, NHS Digital, NHS England and NHS Improvement, Care Quality Commission | For progress within 12 months of publication |
| **14.** Trusts need to capture and analyse the impact of all interventions to assess risks and benefits as part of evidence-based practice. | **a** Trusts to work with system partners and use technological advances to develop robust systems for capturing and reporting the use and impact of interventions – both unwanted outcomes (whether harmful or not) and achievement of desired beneficial outcomes – on an intent to treat basis. | Trusts with support from GIRFT, NHS X, NHS Digital, NHS England and NHS Improvement | For progress within 12 months of publication |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **15.** Trusts need to increase awareness of whether variation is warranted or unwarranted. | **a** Trusts to promote positive variation in terms of better/best practice as it relates to the specific trust. | Trusts with support from GIRFT, NHS England and NHS Improvement, ICS/STPs | For progress within 12 months of publication |
| | **b** Where variation in intervention or outcome relates to not using best, evidence-based practice such as Clozapine or CBTp or Family Intervention in line with NICE guidance, trusts to review reasons for this (including with system partners, if necessary). | | |
| | **c** Trusts to reduce unwarranted variation using guidance such as in LTP EIP services recommendation on increasing NICE concordance. | | |
| | **d** Trusts to flag unwarranted variation to the ICS/STP and PCN where it is due to factors outside of trust control. | | |
| **16.** Trusts need to develop and report robust ways for capturing interventions and outcomes for services that are heavily linked into partnership working (for example, psychiatric liaison offers a range of ways of working with acute hospitals over and above work in urgent and crisis care, older-adult services link into wider initiatives such as Ageing Well/frailty programmes, and crisis response services are typically multi-agency linked). | **a** Trusts to work with system partners to develop robust ways for capturing and reporting the contribution by trust-based services interventions and outcomes to the overall system responses to improving health and wellbeing of people with SMI. | Trusts with support from GIRFT | For progress within 12 months of publication |
| **17.** Reduce litigation costs by application of the GIRFT programme's five-point plan. | **a** Clinicians and trust management to assess their litigation claims covered under Clinical Negligence Scheme for Trust (CNST) notified to the trust over the last five years. | Trusts, GIRFT | For immediate action |
| | **b** Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via *CNST.Helpline@resolution.nhs.uk* | Trusts, GIRFT | Upon completion of action a |
| | **c** Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support | Trusts, GIRFT | Upon completion of action b |
| | **d** Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI)/serious incidents (SI)/Patient Safety Incidents (PSI) and where a claim has not already been reviewed as SUI/SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all staff in a structured format at departmental/directorate meetings (including multidisciplinary team meetings, Morbidity and Mortality meetings where appropriate). | Trusts, GIRFT | Upon completion of action c |
| | **e** GIRFT clinical leads and regional hubs to share with trusts examples of good practice where it would be of benefit. | Trusts, GIRFT | For continual action throughout GIRFT programme. |

# What is adult mental health crisis and acute care?

Adult crisis and acute mental health services encompass the care, treatment and rehabilitation of adults with severe mental illness as part of wider health and social system responses. They cover both urgent and emergency care and planned care.

One in four adults experiences at least one diagnosable mental health problem in any given year.[3] Mental health problems represent the largest single cause of disability in the UK and the leading cause of sickness absence, accounting for 70 million sick days in 2007.[4] Mental illness costs the UK economy as much as £105bn per year.[5]

In 2018/19 more than 3.2 million people accessed Improving Access to Psychological Therapies (IAPT) services and what the NHS Long Term Plan (LTP) describes as serious mental illness (SMI) services – spanning community teams and similar through to acute wards and psychiatric intensive care unit (PICU) services. Although mental health care is often discussed in terms of inpatient treatment, only around 3% of people who accessed services in 2018/19 (and less than 6% of those accessing SMI services) received inpatient care.

The development and increased funding of mental health crisis and acute care are currently tied to the NHS LTP. The commitments of the NHS LTP are designed to enable further service expansion and faster access to community and crisis mental health services. The NHS Mental Health Implementation Plan 2019/20–2023/24 provides the framework whereby the commitments of the NHS LTP can be delivered at the local level.

## A community-based service

NHS mental health provision is essentially a community-based secondary care service, to which an acute inpatient service is attached to serve people when access is essential. Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as quickly and as close to home as possible. Inpatient care, when it is essential, should also be accessible locally and rapidly.

Recent years have seen a reorientation of community mental health care as the result of significant work on the part of NHS England and NHS Improvement. Notably, IAPT has provided millions of people with relatively quick access to treatment where it previously did not exist.

In addition to IAPT, dedicated services such as perinatal care and liaison psychiatry services have expanded on the back of new funding, providing capacity in areas that would have previously been the responsibility of core community mental health teams. Primary care services have also offered some stable patients a route out of secondary care when appropriate, although this has been more successful in some areas than others.

The funding contained in the NHS LTP provides welcome support to the next stage of the expansion of services: the improvement and expansion of core community SMI services.

Timely access to mental health care is important. In many cases, the more time that passes before treatment is accessed, the greater the likelihood that a condition will become more chronic and difficult to treat. Delays to access also make crisis presentations more likely. Presentation in crisis often reduces available options and may lead to a breakdown in community support, making recovery harder to achieve. Timely, equitable access to care must lead to timely effective interventions; otherwise, people can end up in sub-optimal care pathways.

[3] *NHS England and NHS Improvement, 2020. Adult and older adult mental health. www.england.nhs.uk/mental-health/adults/*

[4] *Department of Health, 2013. Annual Report of the Chief Medical Officer 2013 - Public Mental Health Priorities: Investing in the Evidence. www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health*

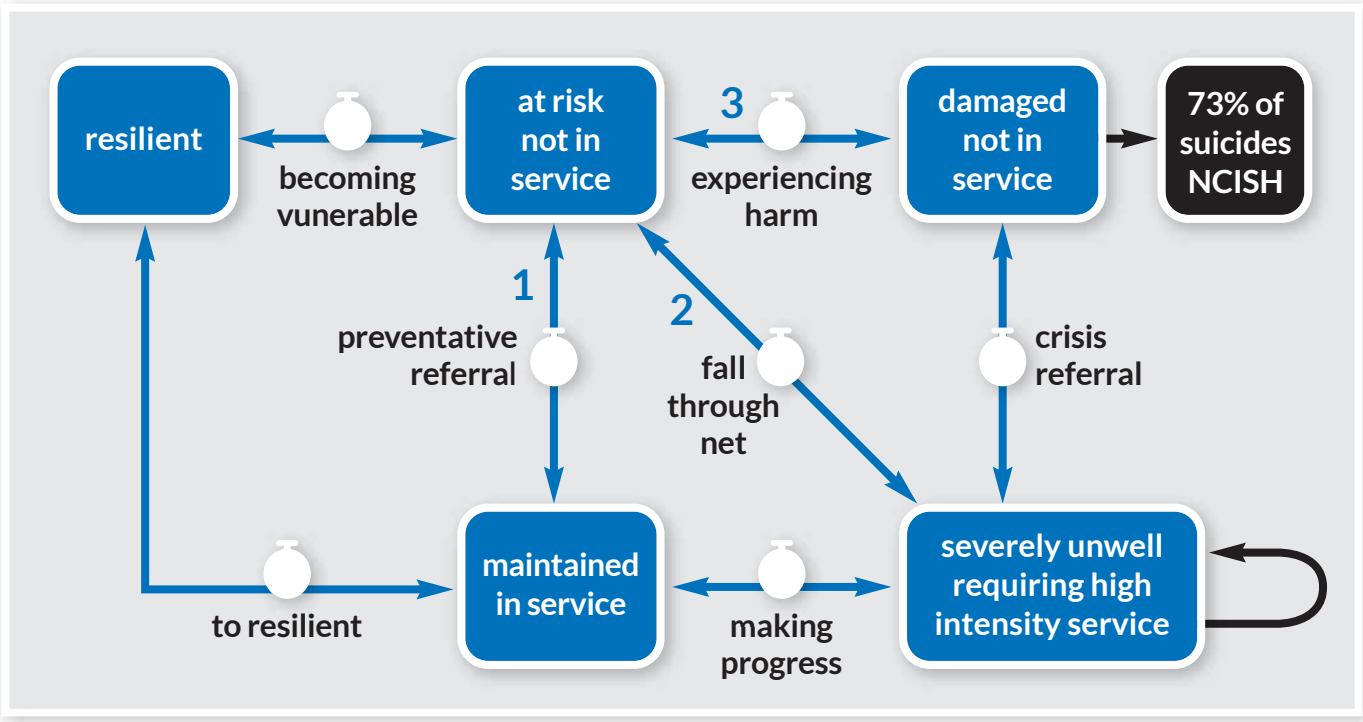
[5] *Public Health England, 2018. Reducing health inequalities in mental illness. www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness*

There are three core pathways through which patients access and undergo mental health treatment:

- **Route 1.** At-risk people enter the service via a preventative referral (typically via their GP or through self-referral) and remain within the service (mostly under the care of CMHTs, IAPT or EIP services) until the purpose of accessing the service has been achieved. This is the best-case scenario, and the pathway that most patients follow.
- **Route 2.** People try to access Route 1 services, but systemic barriers impede that access and/or there are lengthy waits for assessment or essential interventions required after assessment. Some people's conditions then deteriorate without them receiving the necessary intervention. This results in them falling out of Route 1, thus leaving them more likely to present at a late stage in crisis.
- **Route 3.** Some people either do not think they have a mental health condition that will benefit from mental health interventions or have significant worries about accessing mental health services. Such people are at high risk of presenting at a very late stage – often in crisis presentations, which sometimes take place in A&E or via emergency services including the police – raising the potential of secondary and tertiary complications. Challenging Stigma and similar campaigns have helped to encourage more people to seek help earlier, which should reduce the numbers in Route 3, but there is still a lot of work left to be done to demonstrate to local communities that better outcomes follow from earlier access and to address the factors that lead to fear or worry about accessing services earlier.

Difficulties faced by patients in accessing mental health care via Route 1 increase the flow of patients through Routes 3 and 2, resulting in suboptimal access (see **Figure 1**). This leads to increased A&E presentations and higher use of the Mental Health Act (MHA) of 1983.

***Figure 1: Navigating NHS mental health services***




*Source: GIRFT*

Certain social and demographic factors, many of which are covered in detail in this report, are more likely to increase the vulnerability of certain groups to serious mental illness and create barriers that prevent timely access to care. Those affected include (but are not limited to) people living in deprivation or poverty; older people; people with dementia; combat veterans; people with learning disabilities and autistic people; Black, Asian and minority ethnic people; and people with substance misuse problems.

There is significant intersectionality in terms of the factors that make people more vulnerable to serious mental illness and barriers to treatment; often, a person's vulnerability is the result of multiple, combined factors. It is likely that the COVID-19 pandemic has disproportionately worsened the mental health burden for vulnerable groups, while functioning as an additional barrier to care.

## Core services

### Community Mental Health Teams (CMHT)

CMHTs support people living in the community who have complex or serious mental health problems. Patients are able to step down to primary care as their circumstances improve. CMHTs are multidisciplinary; staff can include psychiatrists, social workers, nurses, allied health professionals, psychologists, pharmacists and peer workers.

### Improving Access to Psychological Therapies (IAPT)

IAPT services provide evidence-based treatments for common mental disorders, of which the most common are anxiety and depression. IAPT services provide NICE-recommended psychological therapy to over half a million people each year.[6] Services are delivered using a stepped-care model designed to offer the least intrusive intervention appropriate for a patient's needs.

### Early Intervention in Psychosis (EIP) services

EIP services provide treatment to people who have a provisional diagnosis of first-episode psychosis. EIP services employ staff from different backgrounds, including psychiatrists, social workers, nurses, allied health professionals, psychologists, pharmacists and peer workers.

### Crisis Resolution and Home Treatment (CRHT)

Crisis resolution and home treatment are two separate processes, which in some areas are delivered by one team and in others by two linked services. Crisis resolution services assess people who present in crisis with significant risks to themselves and/or others, and who may require acute mental healthcare. Home treatment services provide treatment, either at home or in community settings such as day centres and crisis houses, for people who are acutely unwell and would otherwise require hospital admission. CRHT teams can admit patients to inpatient care if necessary.

### Inpatient services

Acute inpatient beds are used when a patient has a need for specific interventions that can only be met through acute inpatient care and treatment. Psychiatric intensive care units (PICUs) provide high-intensity care and treatment where it is clearly needed. PICUs usually serve a wider catchment area than CRHTs or admission wards.

[6] *NHS England and NHS Improvement, 2018. The IAPT Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms. www.england.nhs.uk/wp-content/uploads/2018/03/improving-access-to-psychological-therapies-long-term-conditions-pathway.pdf.*

*Table 1: England service provision, April 2018–March 2019*

| Type of service | Metric | Actual | Per 100k registered population |
|---|---|---|---|
| Community mental health teams (CMHT) | Referrals received | 1,611,672 | 3,661 |
| Improving access to psychological therapy (IAPT) | Referrals received | 1,603,650 | 3,643 |
| Early intervention in psychosis (EIP) | Referrals received | 29,272 | 66 |
| Crisis resolution and home treatment (CRHT) teams | Referrals received | 527,089 | 1,197 |
| Adult acute inpatient services | Admissions | 77,570 | 229 |
| Older adult inpatient services | Admissions | 14,853 | 146 |

*Sources: NHS England and NHS Improvement for IAPT data, NHS Benchmarking Network for all others*

## A system of linkages and dependencies

It is a fundamental principle of the GIRFT programme that the advice, examples of good practice and recommendations that are gathered together in each national report lead to better outcomes, fewer delays, fewer secondary and tertiary problems, and fewer instances of patients requiring hospital admission.

In terms of this report, a key overarching part of implementing the recommendations and good practice contained here will involve acknowledging the linkages and dependencies between all levels of NHS mental health care (not just SMI services) and the constituent parts of the wider health and social care system; all of these impact the capacity to prevent SMI and achieve positive outcomes for those affected by SMI. Put simply, getting it right first time at each step reduces the numbers likely to need more intensive levels of care. In turn, this reduces the number of people needing treatment at each step, thus facilitating better use of capacity to deliver effective interventions.

Well-managed flow between different services and different levels of care is a key part of this. Stepping up and stepping down the intensity of care when appropriate, as well as ensuring that access to care operates on an easy-in, easy-out basis, means that fewer people will be stranded in the wrong part of the pathway (or outside of services) at any given time. Addressing mental health issues in this way reduces the risk of people reaching severe or crisis state before they can access appropriate help, as well as reducing the number of people needing inpatient admission.

For those who do reach crisis state, whether requiring intensive home or community-based treatment or inpatient admission, the same principles apply. Patients should receive an appropriate level and intensity of care in a timely manner. Such care should be delivered in ways that are shown to be the most effective, making the best use of available resources and the most up to date evidence.

Trust boards have a unique opportunity for oversight of this whole pathway, and they must ensure that their dashboards give them appropriate, high-quality data. This will allow them to have a firm grasp on the whole care pathway, allowing them to identify where problems might be occurring – and where opportunities exist to further improve local services.

Out of the scope of this report, but still critical to the whole system response, are a range of system partners (including primary care; specialist physical health services; local authorities; police and other emergency services; and the voluntary, community and social-enterprise sector) responsible for dealing with some aspects of access, care, support and overall system capacity. The Mental Health Crisis Care Concordat, published in 2014, recognises many of the issues related to the crossover of work by health, social care and emergency services.[7]

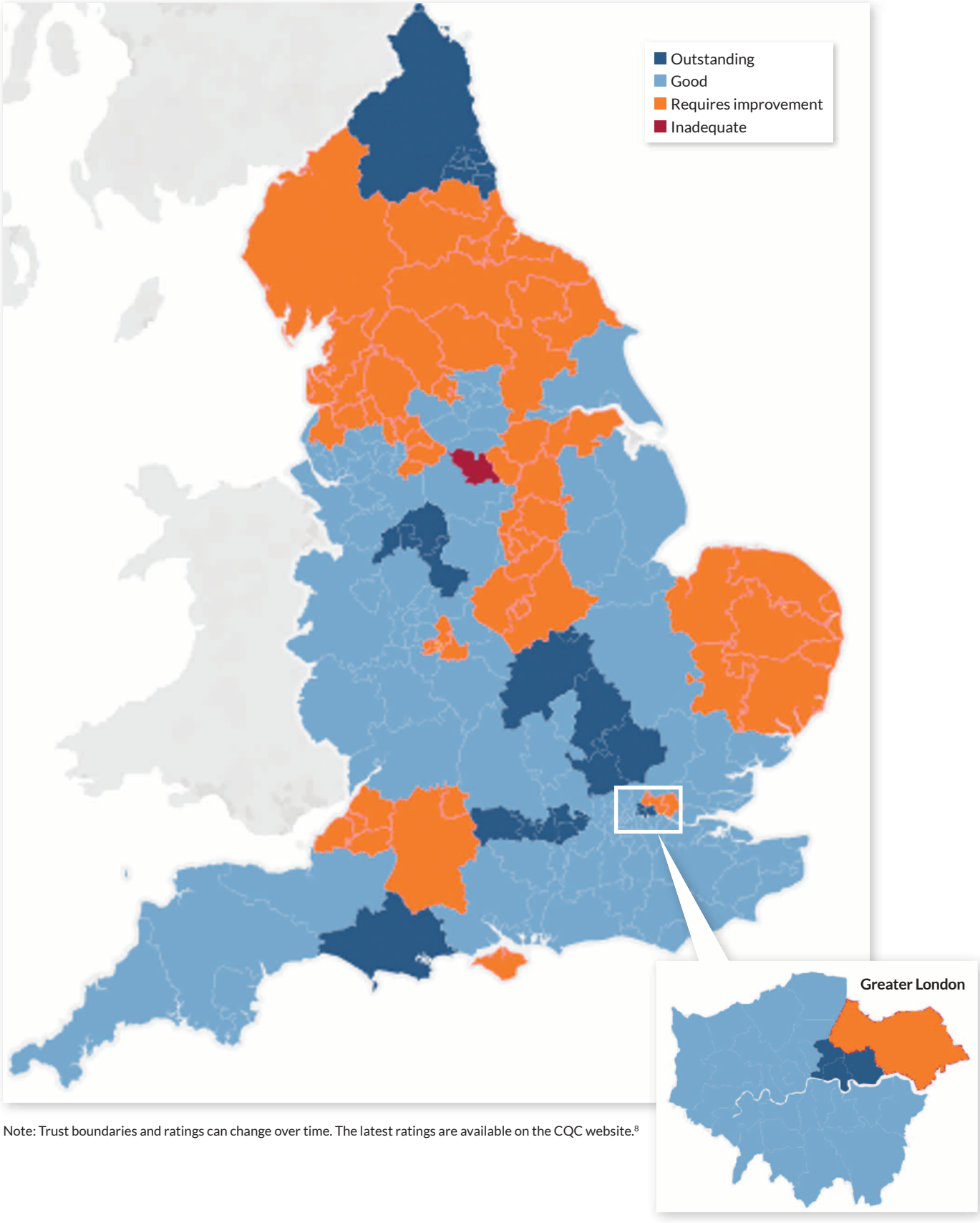
Access, capacity, flow and outcomes are all system-wide issues.

## Assessing trusts

The Care Quality Commission (CQC) rates all mental health trusts based on whether they are safe, effective, caring, responsive and well-led (see **Figure 2**). The latest assessment rates most trusts as 'good' or 'outstanding', although some fall into the 'requires improvement' or 'inadequate' categories. Trusts tend to be large, covering wide areas and types of services, so there will be some internal variability, but the aim is for all trusts to achieve a 'good' rating, with the stretch goal being that as many as possible achieve the 'outstanding' rating.

[7] *Department of Health and Concordat signatories, 2014. Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis. https://s16878.pcdn.co/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf*

***Figure 2: Overall CQC ratings for all mental health trusts, based on whether they are safe, effective, caring, responsive and well-led, 2019.***




Note: Trust boundaries and ratings can change over time. The latest ratings are available on the CQC website.[8]

*Source: Care Quality Commission*

[8] *Care Quality Commission, 2020. Find a Mental Health Service. www.cqc.org.uk/what-we-do/services-we-regulate/find-mental-health-service*

# The scope of this report

Our review focuses on core secondary mental health services for people aged 18 years or over, encompassing services for patients who are at risk of mental health crisis and/or need admission to acute inpatient care (including PICU).

The scope of the report excludes services commissioned by specialist commissioning, as well as certain dedicated services that people may need for particular types of interventions such as eating disorders, and specialist perinatal services. Separate GIRFT programmes cover Child and Adolescent Mental Health, and Mental Health Rehabilitation.

Although we do not specifically review IAPT, we do refer to it, as what is locally commissioned and delivered has a key influence on demand and access to community mental health teams and services.

Similarly, the range of partners who play a part in the overall system response (including but not limited to primary care; specialist physical health services; local authorities; police and other emergency services; and the voluntary, community and social-enterprise sector) are out of our scope, although they are at times referred to and are key components in their own right.

## Key domains within the speciality

We have focused our attention on the areas with the most significant unwarranted variation at national level, all of which offer a clear case for clinical improvement. These include:

- Demand
- Capacity
- Flow
- Outcomes

## Methodology

Our analysis is based on the GIRFT programme model, with the aim of identifying unwarranted variation in practice and outcomes. We used nationally available data sources to help benchmark trusts and also sent a questionnaire to all providers.

A data pack specific to each trust was developed to provide insights into the way that its services function. We then began a process of visiting trusts to present the data in depth to clinicians, senior management and all those involved in delivering services. The data packs and results of the questionnaire were used to support deep-dive and implementation meetings in hospitals, and to support the recommendations in this report.

At the start of the programme 57 providers were covered by our scope, but service reconfigurations since 2018/19 have reduced this number to 55. We had planned to conduct deep-dive visits with all providers, but the outbreak of COVID-19 disrupted this process. Eventually we were able to conduct consultations, either face-to-face or digitally, with 33 providers.

During the consultations, we discussed variations in the data and how each trust stands in relation to their peers. These discussions have informed our findings and recommendations.

Our recommendations and actions should be considered alongside all trust-level actions provided on deep-dive visits, as well as any ongoing work by the Royal Colleges and other professional bodies, NICE, RightCare, NHS England and NHS Improvement (including the NHS LTP), and other bodies working to improve care for patients affected by mental health conditions.

# Data quality and metrics

One overarching difficulty we faced in conducting our analysis was inconsistency in data quality and reporting, including the extremely limited use of outcome measures (other than in IAPT). This is a major factor behind unwarranted variation across mental health services. Although vast amounts of data are recorded within mental health services, their collection and processing tend to be marked by inconsistencies and inefficiencies, hindering attempts to assess the effectiveness of services and plan for the future.

For example, overall patient satisfaction with NHS mental health services is high (at a median of 91% in the NHS Friends and Family Test) but varies notably between providers. In 2018/19 the number of compliments reported about acute mental health services ranged, on an individual provider basis, between 2 and 2054, demonstrating huge variation not apparent in the median score (183).

Beyond reflecting variation in the service, results such as this demonstrate the inconsistency of outcomes reporting – some trusts do not routinely report compliments (hinting at another inconsistency: a focus on assessing care standards using predominantly negative metrics such as use of restrictive practices or serious untoward incidents; these are important to reduce what 'bad' looks like, but they do not help to show what 'good' looks like). Even much trust-level data presents average scores for individual trusts; as most trusts cover large populations and large geographical areas, this obscures internal variation.

This highlights a general point. There remains too much reliance on data being presented as averages or percentages without at the same time giving ranges or underlying numerical values, especially denominators. This can obscure major variation, thus give a misleading picture and in turn hampering strides to improve services.

Key to solving these issues is the proper segmentation of data. A move beyond trust and national-level averages will help to target resources and interventions in ways that provide the best value and that, in combination, are inclusive of the whole population being served. In this report we discuss segmentation of patient data in relation to social and demographic elements that can affect patient vulnerability and barriers to access. Those who we discuss in terms of data segmentation include (but are not limited to) people living in deprivation or poverty; older people; people with dementia; combat veterans; people with learning disabilities and autistic people; Black, Asian and minority ethnic people; and people with substance misuse problems.

There are multiple ways of segmenting data. In this report we have explored some key examples known to have significant potential impact on access and equity.

## Data sources

In addition to GIRFT questionnaire data, we have used the Mental Health Services Data Set (MHSDS) to help benchmark trusts in a national context where possible. However, broad issues with quality and completeness of MHSDS data mean that we have relied on the NHS Benchmarking Network (NHSBN) to fill the gaps. We have also drawn data from a range of other sources, including:

- The National Clinical Audit of Psychosis (NCAP)
- The Health Foundation
- Hospital Episode Statistics (HES) admission data
- The Care Quality Commission (CQC)
- NHS Digital

## Gaps in our analysis

- Our analysis was limited by what is nationally reported and was available to us. A lot of available data is presented on a trust-level basis, which is helpful for comparing trusts but can conceal much variability across individual trust services.
- Aside from what is recorded and available through IAPT, there is a major lack of nationally reported and available data about interventions and outcomes. Most data is top-level process data covering areas such as numbers of contacts, rather than more specific information such as the purpose of a contact and what outcomes have been achieved.
- Data quality was very variable across every metric that we examined. The absence of robust, routine data not only hampers attempts to compare and improve services, it is also a contributory factor behind trusts receiving significant amounts of ad hoc information requests from commissioning and regulatory bodies – adding further pressure to available capacity.

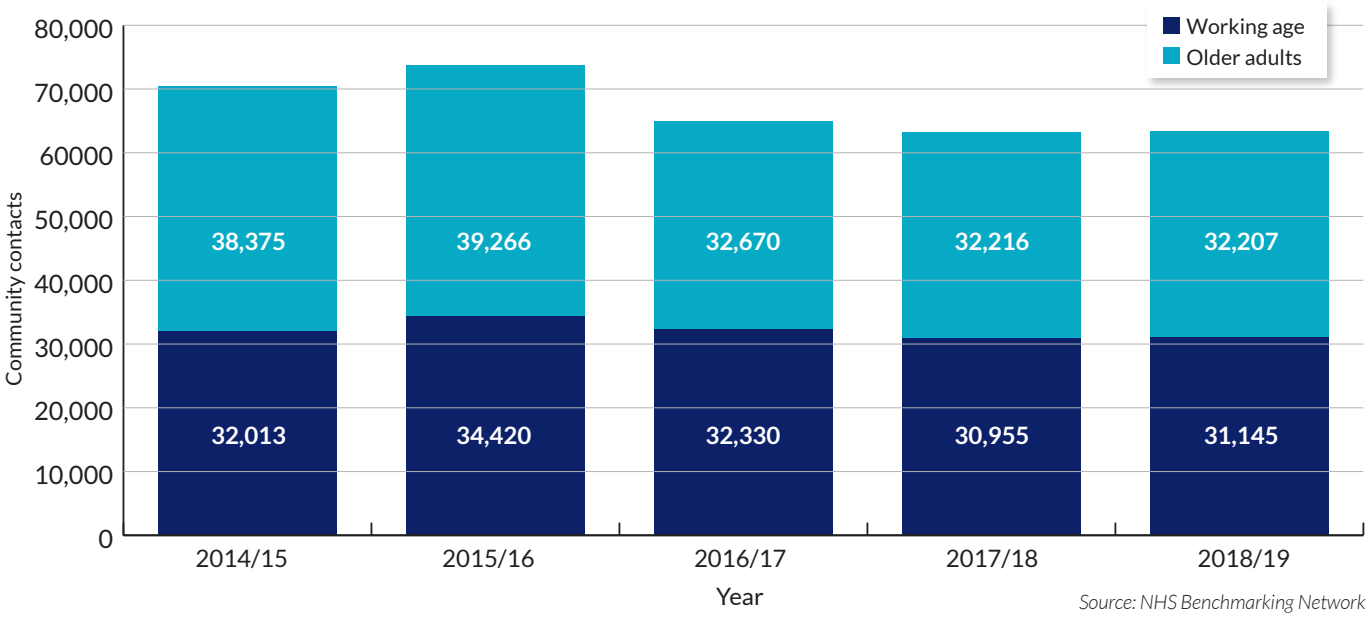
## Demand

A quarter of adults experience at least one diagnosable mental health problem in a given year, and mental illness is the single largest cause of disability in the UK. It is estimated that the economic cost of poor mental health is £105bn per year, far exceeding the NHS mental health budget.[9] People affected by mental illness are also more likely to experience long-term physical health conditions.

An estimated 2.1 million adults were in contact with NHS-funded secondary mental health care, learning disability and autism services (excluding IAPT) in 2018/19.[10] When assessed in terms of individual district councils, the proportion of adults to have had local contact with mental health, learning disability and autism services ranged from 2.5% to 10.8%.[11]

Between 2014/15 and 2018/19, community contacts per 100,000 population reduced by 16.1% in older adult services and 2.7% in working-age services. However, although figures on contacts do give some picture of demand, they also reflect the availability of services.

***Figure 3: Community contacts per 100,000 population, 2014/15–2018/19***




*Source: NHS Benchmarking Network*

Although mental illness affects people in all walks of life, it has a disproportionate impact on certain groups. Examples that we have considered in more detail include people from Black, Asian and minority ethnic communities; older people; dementia sufferers; veterans; homeless people; people who misuse alcohol or other substances; people with learning disabilities and autistic people who do not meet access criteria for learning disability services. Typically, members of these groups tend to find barriers to care harder to overcome, making them less likely to receive timely, effective access and leaving them more likely to either present late (potentially in crisis) or remain stranded out of care.

The variation in impact of access barriers on different groups and individuals is further increased in step with variation in geography, social context and demographics between and within trusts. Gathering an accurate image of nuanced needs and demands in different locations and contexts is an important part of ensuring that demand is met in an adequate and timely fashion. However, present modes of data collection and analysis limit the ability of service planners to do this.

[9] *Public Health England, 2018. Reducing health inequalities in mental illness. www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness*

[10] *NHS Digital, 2019. Mental Health Bulletin 2018-19 Annual report. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2018-19-annual-report*

[11] *Baker, C, 2020. Mental health statistics for England: prevalence, services and funding. London: The House of Commons Library. https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf*

Socioeconomic factors also have a significant impact on mental health. The existence of a specific mental health condition is rarely the sole reason that a person presents in crisis; life events and social circumstances – such as reduction in social network or support, bereavement, or issues with finances or employment – often act as a catalyst. With such factors likely to become more common in response to COVID-19, providers will need to plan services accordingly.

Given the variety of factors that impact on demand for SMI services, service providers must play close attention to the linkages and dependencies that exist between different types of services and parts of the wider health and social care system.

## Social determinants of health

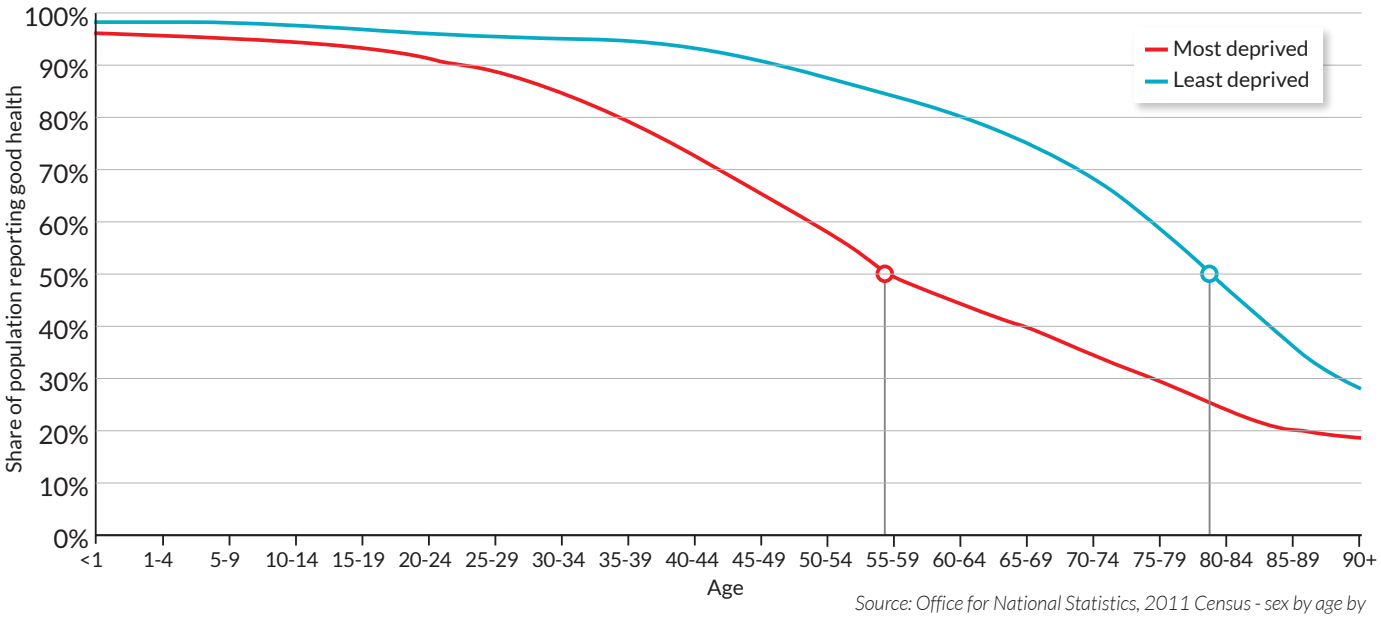
Mental health problems are closely associated with many forms of inequality. These inequalities can begin at an early age, arising from adverse childhood events such as abuse, poor housing, poverty, traumatic events and poor working conditions. In addition, higher rates of poverty, homelessness, incarceration, social isolation and unemployment are likely among people with mental illness.[12]

Demography is one source of variation between trusts that is almost entirely outside of trust control. For example, all trusts have areas of high deprivation, but some are larger than others. There is also a need to plan for age and population ageing while accounting for the fact that age profiles vary both within and between trusts.

Stigma and various types of discrimination are also known to have significant impacts on both health needs and help-seeking behaviour. People from more socially deprived areas are likely to present at a later point in their illness, as well as being more likely to have other co-occurring conditions.

Members of Black, Asian and minority ethnic communities tend to be disproportionately represented among both those affected by inequality and those with mental health issues, while rates of post-traumatic stress disorder (PTSD) rates are disproportionately high among combat veterans, and evidence suggests incidence of depression is higher among older people. In general, there is intersectionality between multiple social determinants of health.

***Figure 4: The impact of deprivation on health - people in deprived areas of England spend less time in good health***




*Source: Office for National Statistics, 2011 Census - sex by age by general health - 2011 deciles IMD2010 from LSOAs in England*

[12] *World Health Organisation, 2014. Social Determinants of Mental Health. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf*

Data from Public Health England demonstrate the impact that social inequalities can have on mental health:

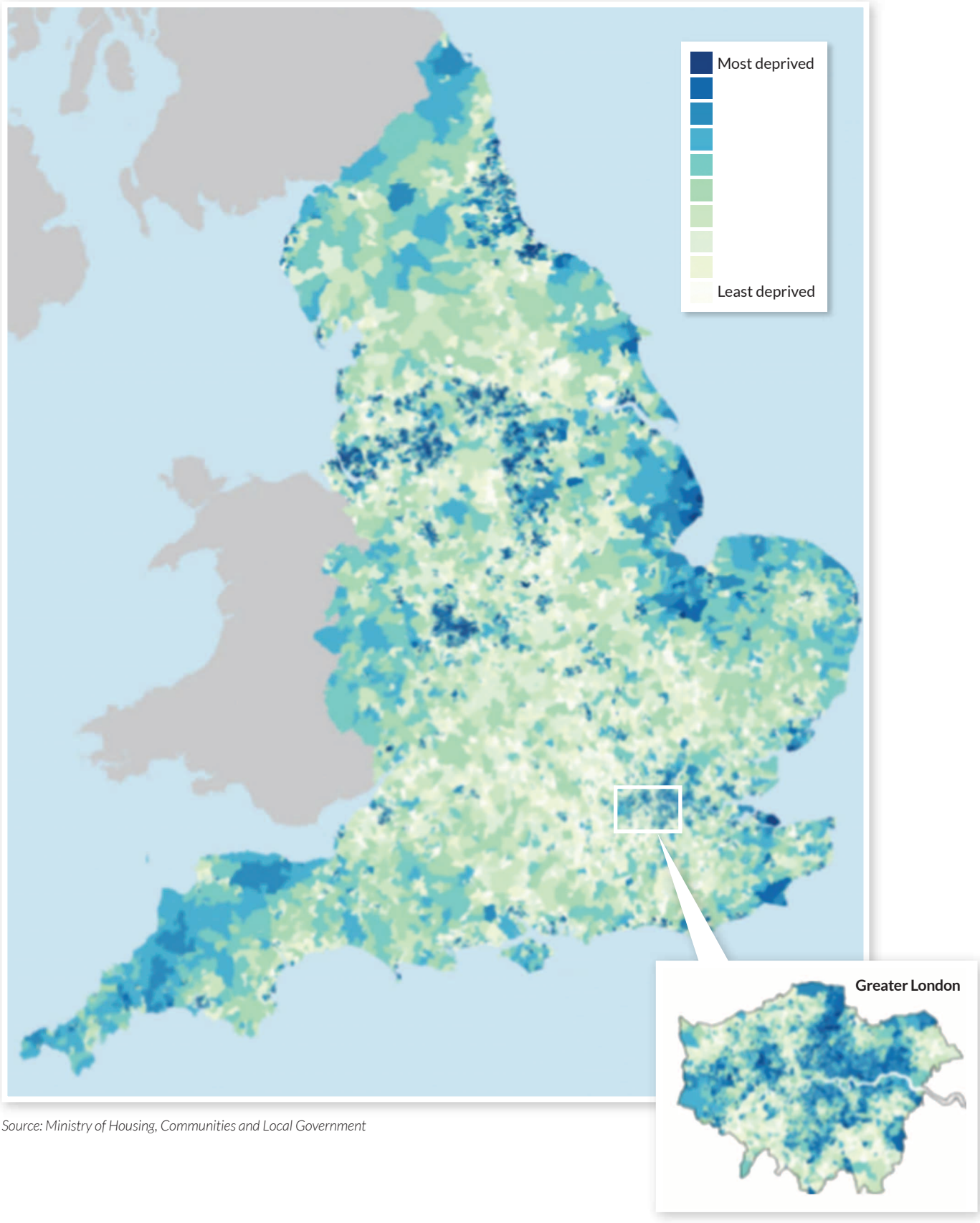
- Psychosis is up to 15 times more prevalent among homeless people.
- In terms of household income, the prevalence of psychotic disorders is nine times higher among those in the lowest fifth of the population than among in the highest fifth.
- The employment rate among those in contact with secondary mental health services is 67.4 percentage points lower than the overall rate.
- Almost 51% percent of Employment Support Allowance claimants have a primary condition of a mental and behavioural problem.
- Fifty-four percent of adults aged 18–69 receiving secondary mental health services on the Care Programme Approach were recorded as living independently, with or without support.
- Life expectancy among people living with severe mental illness is up to 20 years less than the general population.[13]

Social deprivation varies hugely according to geography in England, meaning that demand for mental health services differs widely within and between providers. To plan services accordingly, a comprehensive, nuanced assessment of patient demand is required. In the past, specific sampling of data for minority and high-risk groups has been beset by unintended (and often unacknowledged) bias.

[13] *Public Health England, 2018. Health matters: reducing health inequalities in mental illness. www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness*

***Figure 5: Deprivation across England***

Distribution of the Index of Multiple Deprivation (IMD) 2019 by LSOA in England




*Source: Ministry of Housing, Communities and Local Government*

Public Health England's Mental Health and Wellbeing Joint Strategic Needs Assessment (JSNA) knowledge guide provides an overview of what to consider when thinking about local mental health needs.[14] In addition, the Advancing Mental Health Equality resource is available to support commissioners and providers in efforts to tackle mental health inequalities in local areas.[15]

## Beyond BAME

MHSDS data for 2018/19 shows that around 20.4% of patients enrolled in mental health services are from Black, Asian and minority ethnic backgrounds, which is in line with general population trends (80.5% of respondents to the 2011 census identified as White British, compared with 79.6% of people in MHSDS data).[16] However, the trust-by-trust variation in the proportion of patients categorised under the BAME umbrella is huge, spanning 3.3% at the low end to 67.8% at the high end. It is essential that trusts both use their data to ensure that the proportions of people in contact with services reflect the composition of local communities and can explain any variation in this to ensure that access is equitable.

***Table 2: Provider variation in proportion of mental health patients categorised as BAME in England in 2018/19.***

| | Mean | Median | Range | N providers |
|---|---|---|---|---|
| BAME | 20.4% | 13.2% | 3.3% and 67.5% | 100% (56/56) |
| White British | 79.6% | 86.8% | 32.5% and 96.7% | 100% (56/56) |

*Source: Mental Health Services Data Set*

Beyond planning services to account for local variation in Black, Asian and minority ethnic populations, there is a need for trusts to move away from viewing members of these populations as a single group under the BAME banner. Such a broad focus is not sensitive enough to account for factors that are only picked up through proper segmentation of data. The many cultures and ethnicities within this broad grouping will be characterised by many differences – including barriers to access – as well as certain commonalities.

For example, people identifying as Asian or Asian British are 14% less likely than average to be in contact with mental health services, while those identifying as Black or Black British are 20% more likely to have accessed services in 2018/19.[17] Suicide rates are higher among young black men of African and Caribbean origin – and among middle-aged Black African, Black Caribbean and South Asian women – than among their White British counterparts.[18]

Reporting of ethnicity data is generally high in mental health services (the mean is 84.7%, with little variation on a trust-by-trust basis). Maintaining high reporting levels while introducing proper segmentation would give providers access to a valuable dataset with which to plan locally appropriate services.

[14] *Public Health England, 2019. Mental Health and Wellbeing JSNA. https://fingertips.phe.org.uk/profile-group/mental-health/profile/MH-JSNA*

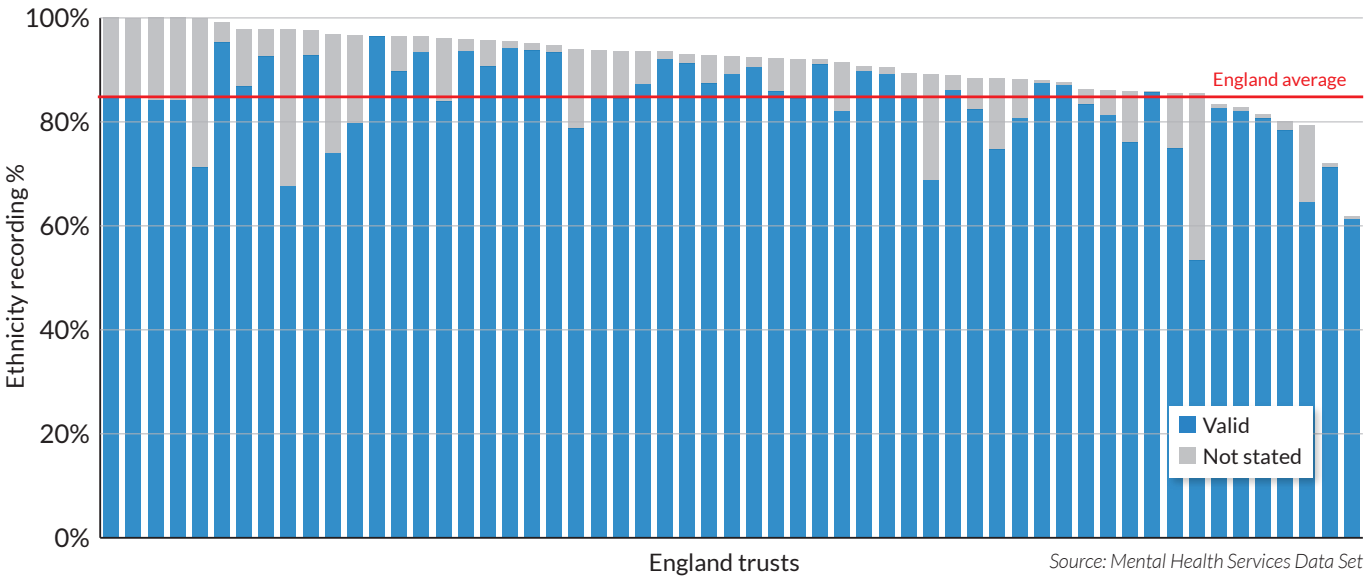
[15] *National Collaborating Centre for Mental Health, 2019. Advancing Mental Health Equality: Steps and Guidance on Commissioning and Delivering Equality in Mental Health Care. London: National Collaborating Centre for Mental Health. www.rcpsych.ac.uk/improving-care/nccmh/care-pathways/advancing-mental-health-equality*

[16] *UK Government Ethnicity Facts and Figures Service, 2018. Population of England and Wales. www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest*

[17] *Baker, C., 2020. Mental health statistics for England: prevalence, services and funding. London: The House of Commons Library. https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf*

[18] *Bhui, K.S., McKenzie, K., 2008. Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. Psychiatr Serv, 59(4); pp.414–20.*

*Figure 6: Ethnicity recording in cases aged over 18, 2018/19*




*Source: Mental Health Services Data Set*

There are also disparities in terms of how people access mental health services. For example, according to Public Health England, people from minority ethnic groups are more likely to:

- seek help in a crisis situation and in A&E;
- be admitted to hospital with a mental health problem;
- experience a poor outcome from treatment;
- disengage from mainstream mental health services.[19]

Black people disproportionately enter services at the more acute and severe level of care (for example, via arrest) and are more likely to be detained under the MHA.

The disconnect that this implies between at least some groups and access to earlier, more preventative access to care is backed up by evidence related to both inpatient admissions and community caseloads. For example, Black people – who make up 3.3% of the population of England and Wales – are over-represented in almost every category of inpatient admission (see **Figure 7**).[20] This is most notable in admissions to medium-secure and high-secure services (24% and 20% of the total respectively), and PICU wards, but is also the case in all but four of the 14 categories. Less pronounced but still significant over-representation in admissions to certain services is present across all ethnic categories apart from White/White British.

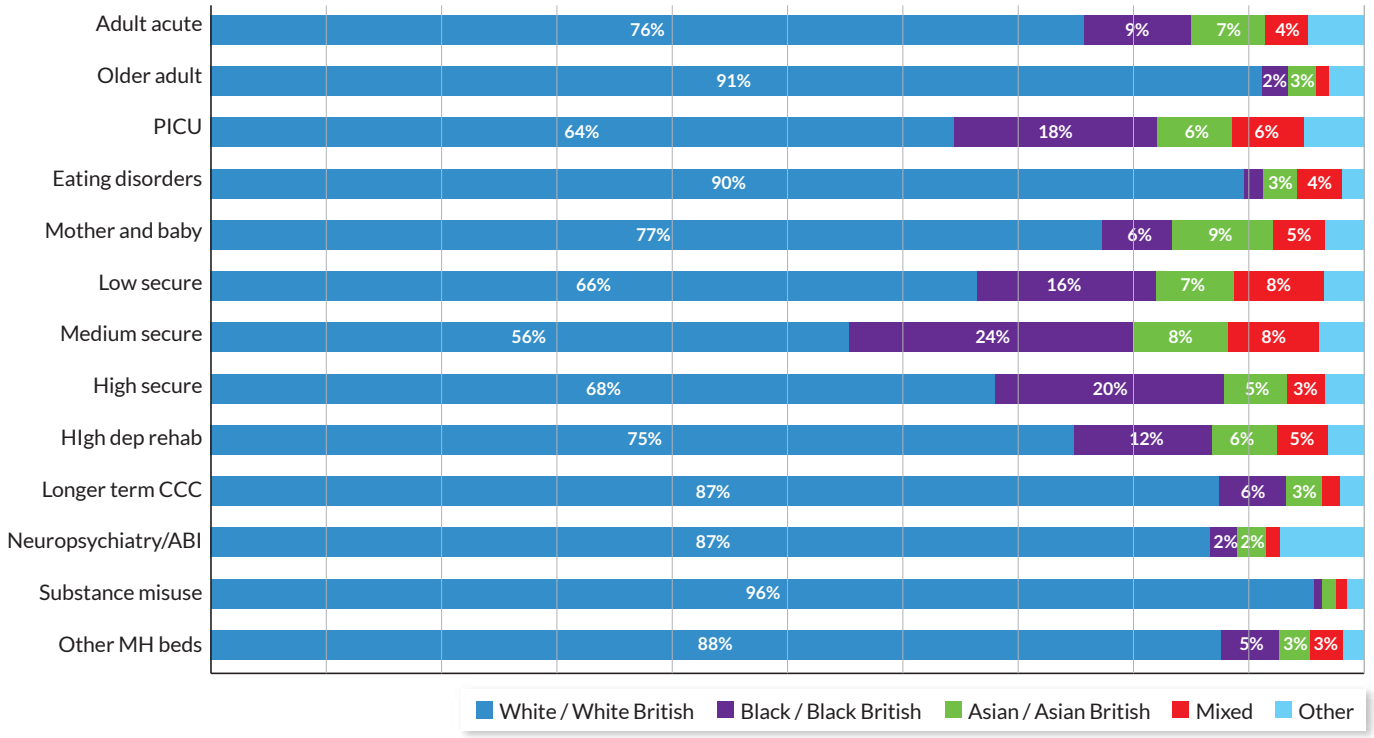
Although such disparities are visible in community caseloads, the rates for more intensive or later-stage services such as assertive outreach, and rehabilitation and recovery, are much higher than they are for core community services (see **Figure 8**). Put simply, while the ethnic breakdown of those accessing core services is similar to the overall population mix, the proportion of Black, Asian and other minority ethnic people is clearly disproportionately high among those in higher-intensity forms of community and inpatient services.

Both the inpatient admission and community caseload data related to ethnicity provide a stark illustration of the fact that if services do not get things right at the beginning, people will disproportionately end up in longer-term and/or more restrictive settings owing to avoidable extra acuity and the accumulation of preventable secondary and tertiary problems.

[19] *Public Health England, 2019. Mental health: population factors. www.gov.uk/government/publications/better-mental-health-jsna-toolkit/3-understanding-people*

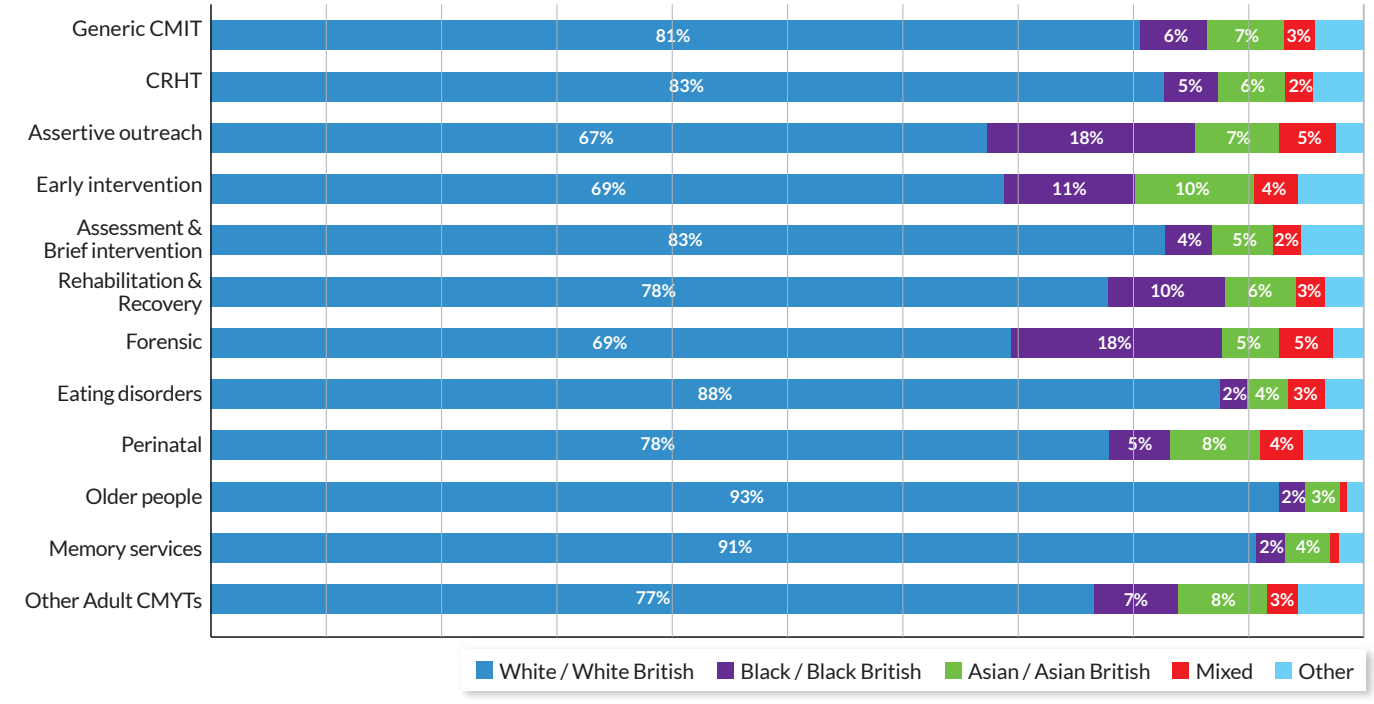
[20] *UK Government Ethnicity Facts and Figures Service, 2018. Population of England and Wales. www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest*

### *Figure 7: Inpatient admissions by service type and patient ethnicity, 2018/19*




*Source: NHS Benchmarking Network*

### *Figure 8: Community caseload by service type and patient ethnicity, 2018/19*




*Source: NHS Benchmarking Network*

Often, the disconnect between mental health services and certain ethnic or minority groups is attributed to community-specific factors, such as distrust of authorities or cultural stigma. However, these types of factors do not excuse the failure of services to engage with patients. It is not useful or acceptable for an open-access public service to place the onus of lack of engagement on the people that it is supposed to serve. Such an approach is counterproductive and suggests that prejudice is ingrained in the system.

Programmes such as the Time to Change campaign seek to challenge stigmatisation and increase peoples' understanding of the need to seek help for mental health problems.[21] However, for too many people there are still multiple barriers to accessing the right help in a timely manner. Systems must find solutions that are positive for all people covered by individual Integrated Care Systems and Primary Care Networks – and mental health providers must play a key part.

***Table 3: Identifying barriers to care***

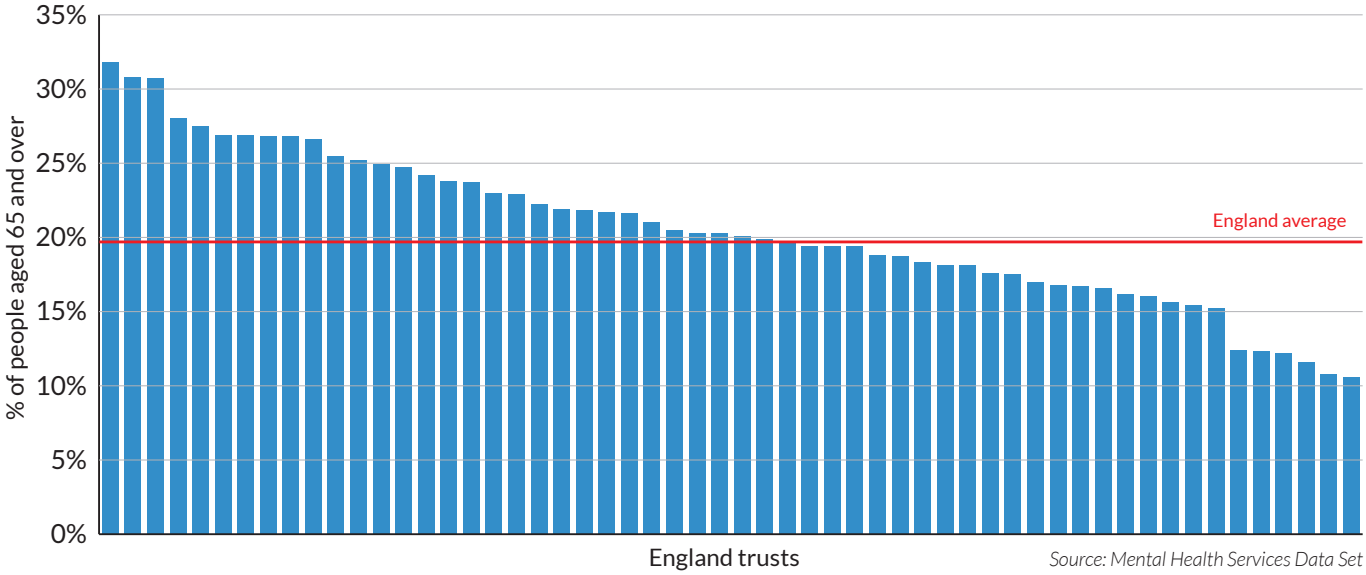
| | Yes (% and number of trusts) |
|---|---|
| Do you have a systematic approach to identify barriers to provision for people who are disproportionately underrepresented in core community services from your local community (e.g. BAME groups, homeless people, people with hearing impairment)? | 42.9% (24/56) |

*Source: GIRFT questionnaire*

## Older people

On average, people aged 65 and over make up about 20% of patients enrolled in mental health services in England, although this varies from between about 10% in some trusts to over 30% at the top end of the scale. Population ageing means that the proportion of people aged 65 and over in the UK is expected to increase from 18% in 2018 to 24% by 2038.[22] This suggests that older people's demand for mental health services will also increase as a proportion of overall demand.

***Figure 9: Proportion of mental health patients aged 65 and over, 2018/19***




*Source: Mental Health Services Data Set*

[21] *Time to Change, 2020. About us. www.time-to-change.org.uk/about-us*

[22] *Office of National Statistics, 2019. Overview of the UK population: August 2019. www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/august2019*

Evidence points to increasing risks and incidence of depression for men older than 75 and women older than 65.[23] Some life events that can trigger depression are more likely to be experienced in older age, including bereavement, perceived loss of status and identity, poor physical health, loss of contact with family and friends, lack of exercise, and living alone.

Social isolation among older people is a particularly significant factor (especially for women) in raising the risk of mental disorders. Survey data shows that at least 10% of older people are socially isolated, with rates even more pronounced for those over 75.[24]

According to the World Health Organisation, loneliness in older people is linked with depressive symptoms, poor mental health and cognition, alcoholism, suicide ideation, and mortality.[25] COVID-19 and preventative measures, such as lockdown and shielding for vulnerable people, will exacerbate the impact of isolation and loneliness on older people. In addition, attention should be paid to the impact that use of remote services has had on older people. Older people tend to be less digitally engaged, meaning that a lack of traditional face-to-face services could present an additional barrier to access to the care and treatment that they need.

A separate GIRFT review focuses on the provision of geriatric medicine, with a particular focus on secondary care. Geriatric care interfaces extensively with primary care, community care and social care as part of the wider health and social care system that encompasses mental health services. Good care is predicated on all of these working well together, and this interface will be addressed within the national report.

## Veterans

Armed-forces veterans are known to be a higher-risk group for some mental health conditions, while also being subject to higher rates of problems with anger, depression, anxiety and alcohol consumption.[26] Rates of PTSD are higher among veterans who have seen combat than among those who have worked in support roles.[27] Veterans have also been reported as taking longer to seek assistance with mental health issues.[28]

According to the GIRFT survey, just under 60% of trusts routinely collect and report data on veteran status at admission to acute services.

***Table 4: Collecting data on veteran status***

| | Yes (% and number of trusts) |
|---|---|
| Do you routinely collect and report on veteran status in people accessing your acute services? | 58.9% (33/56) |

*Source: GIRFT questionnaire*

[23] *McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., Lawton-Smith, S., 2018. Paying the price: the cost of mental health care in England to 2026. The King's Fund.*

[24] *World Health Organisation, 2014. Social Determinants of Mental Health. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1*

[25] *Ibid.*

[26] *Murphy, D., Busuttil, W., 2019. Understanding the needs of veterans seeking support for mental health difficulties. BMJ Mil Health, 166; pp.211-213.*

[27] *Stevelink, S.A.M., Jones, M., Hull, L., et al, 2018. Mental health outcomes at the end of the British involvement in the Iraq and Afghanistan conflicts: a cohort study. BJPsych. 213; pp.690–697*

[28] *Murphy, D., Busuttil, W., 2019. Understanding the needs of veterans seeking support for mental health difficulties. BMJ Mil Health, 166; pp.211-213.*

There is a three-step process in place for veterans seeking mental health treatment:

1. The Veterans' Mental Health Transition, Intervention and Liaison Service (TILS), which launched in April 2017, is a dedicated outpatient service that provides treatment for veterans struggling with alcohol and drug abuse. It also offers social support, such as help with employment, housing, relationships and finances.
2. The next level of treatment is available through the Veterans' Mental Health Complex Treatment Service (CTS), which provides an enhanced service to veterans who have unresolved military-attributable complex mental health problems. The CTS is accessible via the TILS.
3. A new service is in development to offer care beyond the TILS and the CTS. The Veterans' Mental Health High Intensity Service is designed to provide both inpatient and community crisis care. Given that pathfinder tests for the service are due to run from June 2020 until March 2022, mobilisation of the programme will have to take place amid the challenges (and possible increased demand) created by COVID-19.

Support in the NHS LTP for local transition, liaison and treatment services to provide support for a range of healthcare and social needs includes access to complex treatment services and targeted interventions for veterans in contact with the criminal justice system. The Veterans Covenant Healthcare Alliance (VHCA) is one initiative that is already seeking to optimise the healthcare that veterans receive from the NHS. Fifty-three mental health and acute trusts are accredited as Veterans Aware by VHCA.

CASE STUDY

## Strengthening connections between veterans and local services

### Camden and Islington NHS Foundation Trust Veterans' Complex Treatment Service

Camden and Islington has worked to tailor care for patients with psychiatric symptoms associated with trauma in combat. Such patients can experience marked anger and concern linked in part to not understanding their symptoms, and often they use addictive substances to manage symptoms.

Such patients can be ambivalent about seeking treatment, as well harbouring concerns about others' understanding of veterans' issues and potential limitations in the flexibility of local response.

The Veterans' Complex Treatment Service sets out to strengthen connections between such patients and local mental health and primary care services in a way that is sensitive to military-specific issues.

Following liaison with core local services, a patient may be allocated a clinician to begin the process of building rapport, encouraging the patient to discuss their mental health difficulties, and undertaking preparatory symptom management and emotion-regulation strategies. Such an approach works towards fostering a good working relationship with NHS clinicians and support workers.

The potential benefits include:

- the person being able to remain in employment, and undertake a graded return to work;
- being better to regulate emotion and manager anger over the course of the therapy;
- no further contact with crisis services being required.

Substance use may also decrease as a patient becomes more able to manage distress using alternative strategies.

## Learning disabilities and autism

An estimated 30% of adults with learning disabilities experience mental health problems at any point in time, a proportion far higher than among people not affected by learning disabilities.[29] Learning disabilities and autism affect both working-age and older adults, and so any consideration of the crossover with mental health problems should cover both age groups.

People with all levels of learning disabilities can be affected by mental health problems. Mental health problems can be difficult to identify when a person is less able to express their distress. In addition, coexisting physical health problems can make mental health problems difficult to identify. This leads to mental health problems remaining unrecognised, prolonging unnecessary distress and potentially delaying admission to care.

Whereas dedicated learning disability services will provide services to people with moderate or more severe learning disability, many people with mild learning disability do not qualify for access to learning disability teams and so will present to mental health teams for help in addressing mental health problems. In addition, when people with learning disabilities experience mental health problems, symptoms are sometimes wrongly attributed to the learning disabilities or a physical health problem rather than a change in mental health.

Eight out of ten autistic adults experience mental health problems during their lifetime, and roughly 40% of people diagnosed with autism have symptoms of at least one anxiety disorder at a time, compared with 15% of the general population.[30,31] Obsessive compulsive disorder and depression are also more common among autistic people, while autism is also more common in people with learning disabilities. As the majority of autistic people do not have a learning disability, they will present to mental health services for help in addressing mental health problems.

CASE STUDY

### Maintaining support for people with learning disabilities amid COVID-19

**Surrey and Borders Partnership NHS Foundation Trust**

In recent years Surrey and Borders has implemented a range of measures to ensure equal access to IAPT for people with learning disabilities, including the operation of wellbeing groups. Since the start of the COVID-19 pandemic, however, these in-person groups have largely been on hold. One exception, a reference group operated by the trust, has continued to meet to discuss alternative ways of meeting the psychological needs of people with learning disabilities.

Since the pandemic began, the trust has run ten two-session wellbeing interventions for individuals or small groups of people who have shown mild to moderate anxiety and depression, in the process supporting them to develop a personalised wellbeing plan.

Responding to an increase in the use of digital platforms by people with learning disabilities, the trust is now planning to resume all of its wellbeing groups, run jointly by Mind Matters (the Surrey and Borders IAPT service) and the local Community Team for People with Learning Disabilities, in January 2021.

Seeking to provide further support during the pandemic, the trust has also produced a series of videos offering advice and guidance. So far, the trust has produced 20 videos for people with learning disabilities and 13 videos for carers. These address issues around COVID-19, covering practical aspects such as requirements to socially distance and wear face masks, but focusing particularly on reducing anxiety and depression, and issues of bereavement. To date, the videos have received almost 31,000 views.

[29] *NICE, 2016. Mental health problems with learning disabilities NICE quality standard. www.nice.org.uk/guidance/qs142/documents/draft-quality-standard*

[30] *Harper, G., Smith, E., Simonoff, E., Hill, L., Johnson, S., Davidson, I., 2019. Autistica Action Briefing: Adult Mental Health. Autistica. www.autistica.org.uk/downloads/files/Autistica-Action-Briefing-Adult-Mental-Health.pdf*

[31] *National Autistic Society, 2020. Mental health and autism. www.autism.org.uk/about/health/mental-health.aspx*

## Substance misuse and mental health issues

Uncertainty surrounds the prevalence of dual diagnosis of mental health issues and substance misuse. Studies have estimated prevalence rates of 20–37% in secondary mental health services and 6–15% in substance misuse settings; however, methodological and reporting challenges mean that it is unclear how many people are affected by dual diagnosis.[32] Both working-age and older adults are affected by substance misuse and its interaction with mental health problems.

The Co-occurring Substance Misuse and Mental Health Issues Profiling Tool has been developed to support an intelligence-driven approach to understanding and meeting need. The tool collates and analyses a wide range of publicly available data around tobacco smoking, alcohol use and drug use, including data on prevalence, risk factors, treatment demand and treatment response.[33]

## Demand and COVID-19

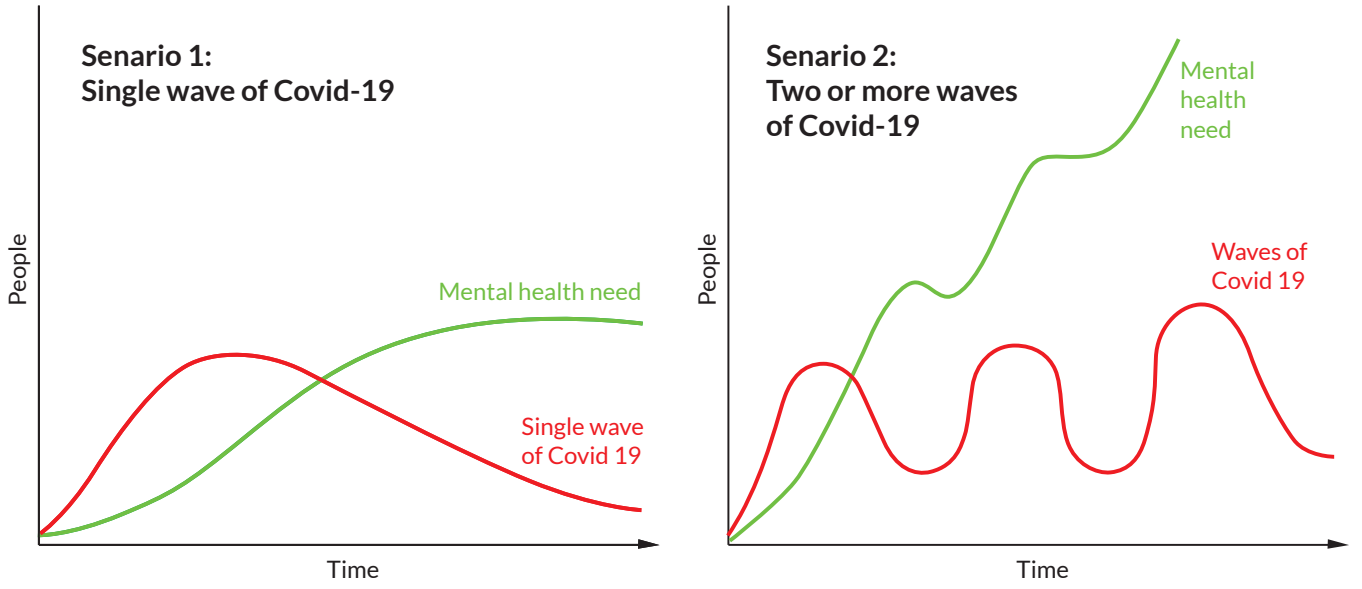
The sudden imposition of COVID-19 on people's lives raises major uncertainty regarding the incidence and impact of mental health conditions, and short- and long-term mental health service planning. According to a forecast published by the Centre for Mental Health in May 2020, at least half a million additional people in the UK may experience mental ill health as a result of COVID-19.[34]

The impact that the COVID-19 pandemic will have on wider society and mental health services is yet to be fully understood. Considerations should be made for direct impacts arising from COVID-19 infection, alongside indirect effects arising from lockdown and social isolation, disruptions to normal patterns and routines, and economic pressures.

Some groups face especially high risks to their mental health. This higher-risk group includes people with pre-existing long-term physical and/or mental health conditions, especially where care may have been disrupted. The direct impact of COVID-19 has also been demonstrated to be unevenly distributed across society, with people from certain ethnic backgrounds, occupations and age groups at higher risk of infection, complications and death. It is less well documented but increasingly suspected that the mental health impacts of COVID-19 will also impact disproportionately on those already most vulnerable.

***Figure 10. Potential interactions between COVID-19 and mental health demand***

Scenarios of mental health need relating to Covid-19 and how they could compare with the trajectory of the virus itself




*Source: Centre for Mental Health*

[32] *NICE, 2015. Severe mental illness and substance misuse (dual diagnosis): community health and social care services: evidence review. www.nice.org.uk/guidance/ng58/documents/evidence-review*

[33] *Public Health England, 2020. Co-occurring substance misuse and mental health issues. https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth*

[34] *Centre for Mental Health, 2020. COVID-19 and the nation's mental health. www.centreformentalhealth.org.uk/COVID-19-nations-mental-health*

## Short-term consequences of COVID-19

The effect of lockdown measures on people's usual activities, routines and livelihoods may lead to increased levels of loneliness, depression, PTSD, harmful alcohol and drug use (difficulties in accessing recreational drugs could also lead to potential overdoses when availability increases), and self-harm or suicidal behaviour.

Early emerging evidence suggests that increased numbers of new patients are presenting to mental health services. Similarly, early evidence also suggests that some existing patients are presenting with more severe symptoms, which are more difficult to treat in the community. Reduction in community services linked to the impact of COVID-19 appears, at least in some areas, to have been a contributory factor to later and more severe presentations of mental health conditions, including increased admissions to hospital.

Acknowledged direct short-term consequences of COVID-19 include anxiety, depression and exacerbation of existing psychotic symptoms. Bereavement may be one cause of depression. An increase in alcohol misuse and other addictions is also possible. According to a survey of 16,000 people conducted by MIND during lockdown, 65% of adult participants with a pre-existing mental health problem said that their symptoms had worsened since lockdown was imposed.[35]

Remote outreach and screening will help to assess the mental health burden of COVID-19, as well as bringing extra patients into the service. NHS Digital has said that video assessments should be used to reach people where in-person contact cannot be safely and effectively delivered.

In addition to the potential benefits of video assessments and other digital interactions with patients, close attention should be paid to the potential inequality issues to access created by remote outreach. There is concern that significant numbers of the UK population remain digitally excluded. The 2020 Consumer Digital Index estimates that 9 million people (16% of the UK population) cannot undertake foundation digital activities such as turning on a device, connecting to wi-fi or opening an app by themselves.

Evidence suggests that the most vulnerable and disadvantaged are the most likely to be digitally excluded. Age, particularly when coupled with BAME backgrounds, has been identified as the biggest indicator of low digital engagement. The costs of devices and wi-fi services alone may prevent some people being able to access care.

## Medium-to-long-term consequences of COVID-19

Likely medium-to-long-term consequences of COVID-19 that are likely to be detrimental to people's mental health include economic impacts such as unemployment, job insecurity, income reduction, increased debt, housing loss and loss of socio-economic status.

Other possible consequences include anxiety, depression and PTSD arising from post-ICU syndrome. Bereavement may lead to prolonged traumatic and complicated grief. There may also be increases in levels of depression, suicide, alcohol misuse and other addictions. There is also a likelihood of adversely affected personal relationships, including domestic violence, anxiety and depression. Loss of routine and reduced regular contact with social networks are likely to have a higher impact on older adults, especially as they are more likely to have to 'shield' away from public places.

Working on the frontline of COVID-19 care may also have impacts on health and care personnel, potentially in the form of PTSD. Close attention should be paid to the welfare of healthcare staff.

Subsequent surges of COVID-19 following the first wave of the pandemic are likely to exacerbate and worsen the initial impact on mental health.

[35] *MIND, 2020. The mental health emergency: how has the coronavirus pandemic impacted our mental health? www.mind.org.uk/media-a/5929/the-mental-health-emergency_a4_final.pdf*

[36] *Lloyds Bank, 2020. Lloyds Bank UK Consumer Digital Index 2020. www.lloydsbank.com/assets/media/pdfs/banking_with_us/whats-happening/lb-consumer-digital-index-2020-report.pdf*

[37] *UK Government Ethnicity Facts and Figures Service, 2020. Internet use. www.ethnicity-facts-figures.service.gov.uk/culture-and-community/digital/internet-use/latest#by-ethnicity-and-age-group*

## Adapting to COVID-19

The Centre for Mental Health has made some recommendations in relation to mental health and COVID-19:

- The Government and Public Health England should advise and support schools, health and care services and businesses in trauma-informed approaches to manage the psychological safety of employees and workers once the lockdown is lifted.
- The NHS should develop a proactive and tailored offer of mental health support to people who have received hospital treatment for COVID-19, those working in healthcare services with people with COVID-19 and those bereaved during the pandemic.
- The NHS should prepare for both a V-shaped (sharp recession, sharp recovery) and a W-shaped (repeated downturns) recession during the next five years, in preparation to respond either to a single, deep recession or to a series of economic shocks and the likely consequent impacts on mental health.[38]

Another useful resource is the COVID-19 Change Package developed by the COVID-19 Mental Health Improvement Network.[39] This package of approaches focuses on effective communication with staff, patients, and families and carers. The main areas of focus are alternative approaches to communication (such as video calls and virtual groups), and positive, compassionate strategies in terms of treatment, care and staff welfare.

CASE STUDY

### Clinical prioritisation and routes of access during COVID-19

**Cheshire and Wirral Partnership NHS Foundation Trust**

As the country entered lockdown in March 2020, clinicians in Cheshire and Wirral agreed criteria by which known and new patients would receive face-to-face care. The clinical prioritisation was based on needs, risk and risk of deterioration. A prioritisation document was reviewed by the Clinical Ethics Forum to ensure ethical oversight of prioritisation.

The trust also set up a 24/7 All Age crisis telephone line – doing so in one week. The line is able to support individuals and their loved ones after discharge from inpatient wards, including through provision of psychosocial interventions.

The trust cites several benefits of the approach that it has taken:

- Clarity regarding clinical prioritisation has given staff clarity about their roles and responsibilities in a challenging time, including when staff have been deployed from other teams.
- A newly developed dashboard has helped the trust to record the impact of changes in practice and clinical prioritisation, including in terms of admissions. Face-to-face contacts have increased since summer 2020.
- The trust did not send any patients to an acute out of area bed during the first two waves of the pandemic.

The trust is doing further work regarding the use of digital technology to deliver treatment interventions. The aim is to optimise delivery of interventions through digital routes.

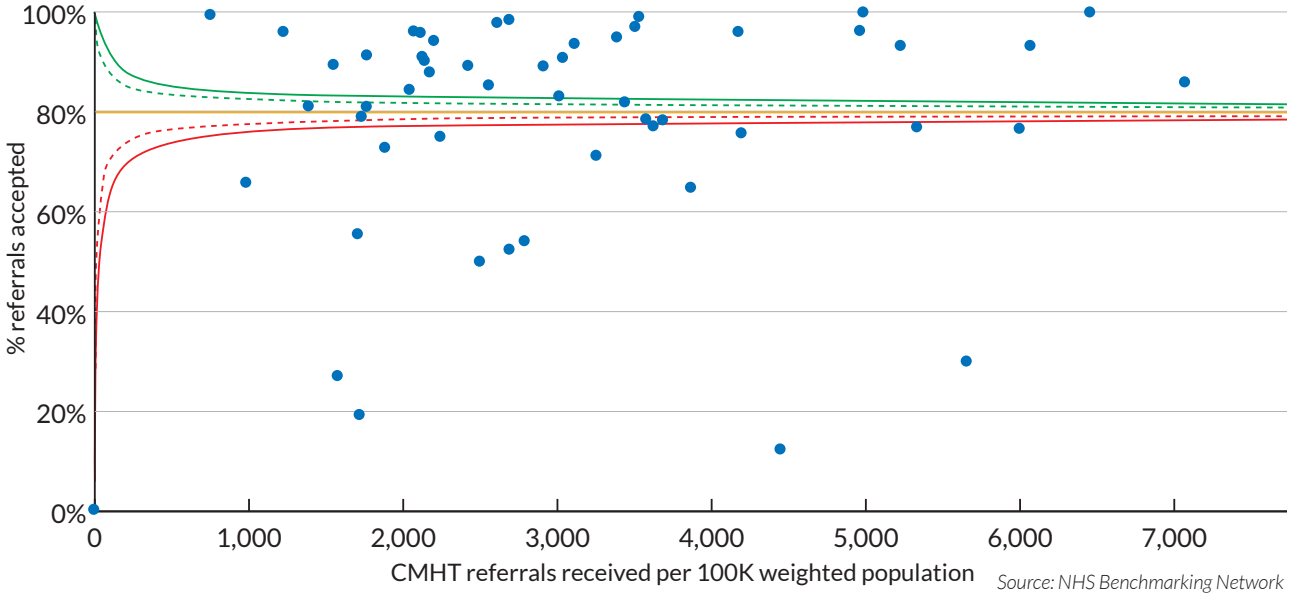
[38] *Centre for Mental Health, 2020. COVID-19 and the nation's mental health. www.centreformentalhealth.org.uk/COVID-19-nations-mental-health*

[39] *COVID-19 Mental Health Improvement Network, 2020. COVID-19 Change Package - Communication: with families and carers, patients, and staff. www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/COVID-19-network/nhsei-change-package-for-communication.pdf*

## Funnel Plots

Funnel plots are a good way to identify and show variation. For example, **Figure 11** shows the variation in the proportion of CMHT referrals accepted by trusts in 2018/19.

***Figure 11: CMHT referrals received and accepted, 2018/19***




*Source: NHS Benchmarking Network*

### How funnel plots work

The x-axis plots the volume metric (number of referrals received per 100,000 weighted population) and the y-axis plots the outcome metric (percentage of referrals accepted). Each black dot represents a specific provider. The mean value for the population (in this case 79%) is shown by the amber line.

The curves on either side show the likelihood of an outcome varying from the average due to chance alone:

- The inner curves (the dotted lines) show 2 standard deviations from the mean. 5% of values are likely to be beyond these curves due to chance.
- The outer curves (the solid lines) show 3 standard deviations from the mean. 0.3% of values are likely to be beyond these curves due to chance.

### Accuracy and volume

When there is less volume (x-axis), the accuracy of calculating the variation due to chance is poorer, so the funnel curves are further from the average. When there is greater volume, the accuracy of calculating the variation due to chance is better, so the funnel curves are closer to the average.

### Variation due to chance

Providers that sit outside these curves are the outliers. In **Figure 11**, the vast majority of providers have either higher or lower than expected acceptance rates.

### Variation caused by other factors

All things being equal, funnel plots accurately show the variation from the average. However, **Figure 11** includes far more providers with outcome values above or below the outer ranges of the funnel than might be expected. This is called 'over-dispersion' and indicates that things are not necessarily equal – other factors may be influencing the data.

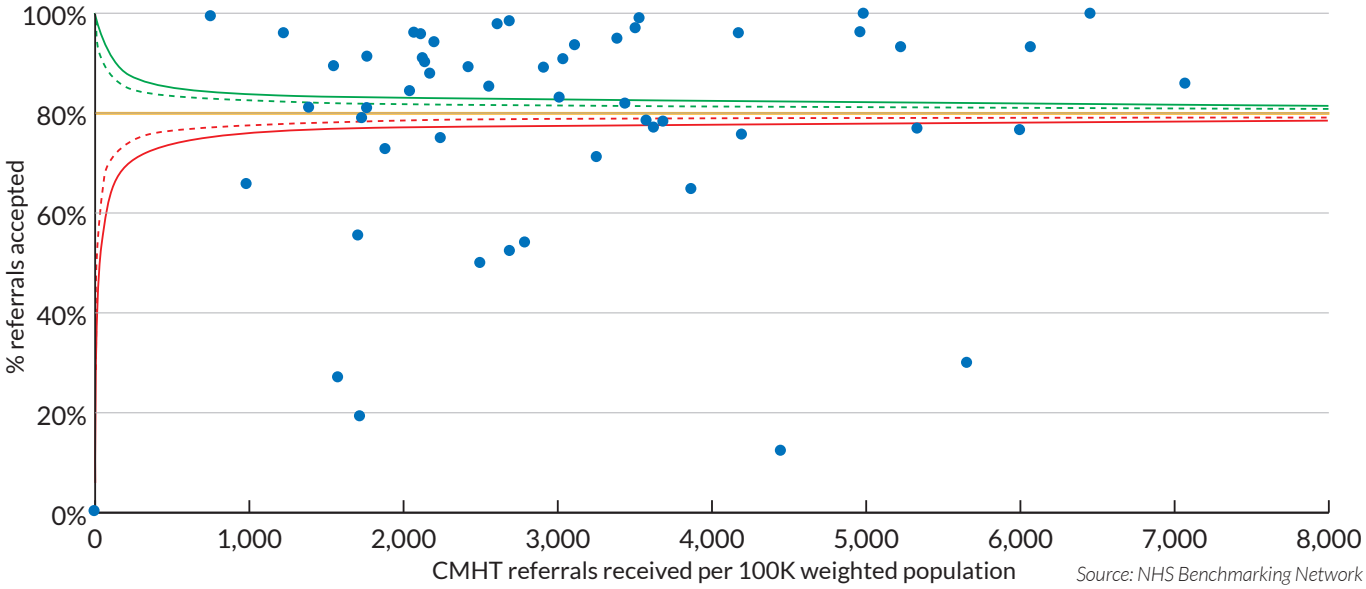
In this example, it could be due to vast discrepancies in the practices of different providers – with potential implications in terms of access, capacity, flow and patient outcomes. There could also be discrepancies in how the data is recorded. Either way, the implication is of significant unwarranted variation, a factor not hinted at by the mean level.

## Unmet demand

Assessment of unmet demand within NHS mental health services is complicated by a lack of specific data (there is no specific measure). The only information available is on the numbers of people turned away, and the number under the care of a specific team. The information that is available is very much process based.

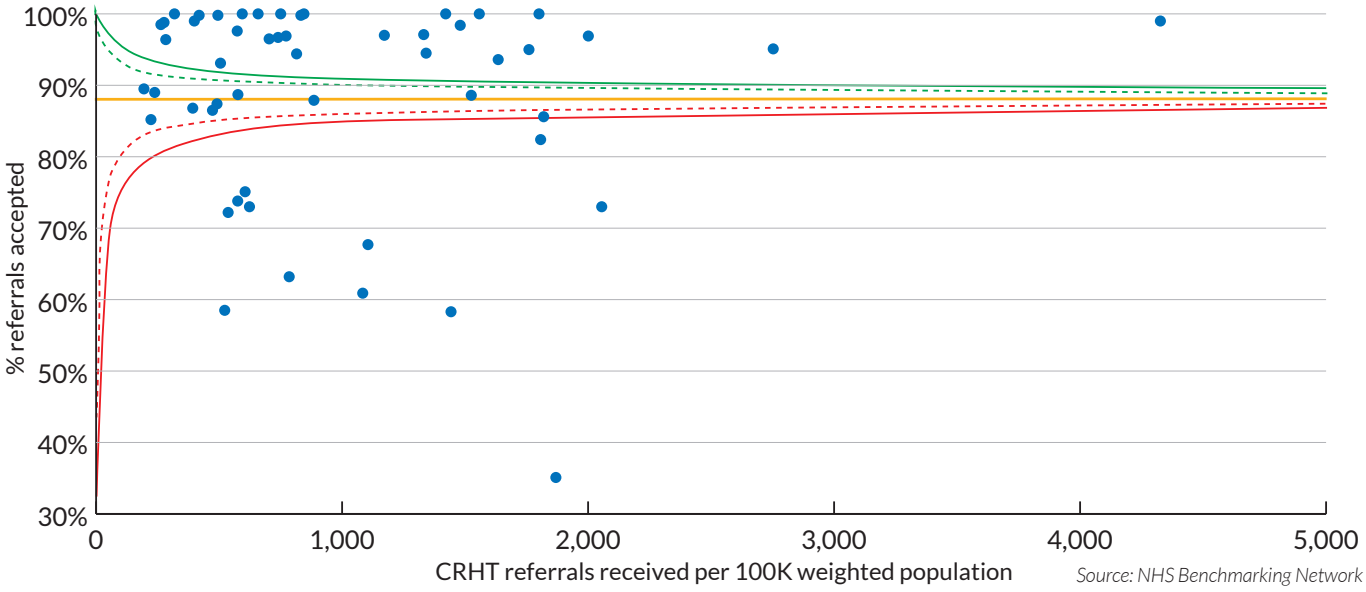
A combination of robust data on referrals per weighted 100,000 population, acceptance per weighted 100,000 population and did-not-attend (DNA) rates for new referrals would give a clearer picture of unmet demand. Assessment of unmet demand also requires segmentation to identify any underrepresented sectors of the local community, and the predicted need for such sectors. In 2018/19 79% of CMHT referrals and 88% of CRHT referrals were accepted overall, although there is significant variation among trusts, as there is with DNA rates.

***Figure 11: CMHT referrals received and accepted, 2018/19***




*Source: NHS Benchmarking Network*

***Figure 12: CRHT referrals received and accepted, 2018/19***




*Source: NHS Benchmarking Network*

***Table 5: Provider DNA rates, 2018/19***

| | Mean | Median | Range |
|---|---|---|---|
| Generic CMHT | 12% | 4% and 20% | 87.7%(50/57) |
| Crisis resolution home treatment | 6% | 1% and 16% | 86.0%(49/57) |
| Assertive outreach | 11% | 3% and 20% | 29.8%(17/57) |
| Early intervention (including early-onset psychosis) | 11% | 5% and 19% | 86.0%(49/57) |
| Assessment & brief intervention (including PMHT) | 12% | 1% and 27% | 54.4%(31/57) |
| Older people CMHT (excluding memory clinics) | 4% | 1% and 10% | 84.2%(48/57) |

*Source: NHS Benchmarking Network*

Unmet demand is primarily an issue arising from insufficient community capacity, but it can drive an overflow in inpatient bed numbers (by causing both preventable inpatient admission and delayed discharge) and out-of-area placements (OAPs). The Commission on Acute Adult Psychiatric Care found that 30% of delayed discharges from hospital are associated with the absence of good-quality, well-resourced community teams.[40]

The Royal College of Psychiatrists recommends that inpatient bed occupancy rates should be no more than 85%, which is a sufficient margin to set over an extended period. However, more accurate data on shorter-term flows and surges would help to manage inevitable fluctuations in demand for admission and ensure that patients who do require admission can be admitted in a timely manner, and close to home.

Even when people do experience a mental health crisis, there is no guarantee that they will successfully access help – 73% of suicides in England in 2007–17 involved those not enrolled in care for SMI.[41] The Royal College of Psychiatrists has recently published a report on suicide in the UK.[42] Its findings suggest that at-risk patients are not being identified and/or offered treatment that could prevent their death.

## Measuring demand: data aggregation and clustering

Improving the readiness of services to meet local demand can only be done effectively when a comprehensive, nuanced body of data is available with which to assess services across and within trusts. Data should be segmented and combined with local knowledge, so that service planning can become a more meaningful and bespoke service.

At present, high-level data is often aggregated, which limits how much knowledge can be gleaned from what is being reported. For instance, average data measures for a trust that covers a large population and geographical area may mask significant variation within the trust, meaning that granular information is lost.

One area of existing data reporting that offers limited benefit is clustering, a system that was primarily brought in to help to develop a more effective payment model than block contracts. Based around 21 care clusters, clustering is designed to stratify the level of need and risk that a person has, in addition to recording their diagnosis.

There are various issues with clustering that limit its use to clinicians and service planners. For example, clustering does not predict who will need which types of interventions or stepped-up care (to inpatient care, for example); neither does it capture which other conditions a person is suffering from – a significant blind spot, given the prevalence of comorbidities among mental health patients.

The use of clinical coding would provide a fuller picture covering treatment, diagnosis, complications and comorbidities. Access to such data, properly reported and analysed, would offer true benefits in terms of service planning in ways that clustering does not. With this in mind, the NHS LTP mandates that all trusts become compliant with the SNOMED-CT platform by 2020/21.

[40] *The Commission on Acute Adult Psychiatric Care, 2015. Improving acute inpatient psychiatric care for adults in England. The Kings Fund. www.kingsfund.org.uk/sites/default/files/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf*

[41] *The National Confidential Inquiry into Suicide and Safety in Mental Health, 2019. Annual Report: England, Northern Ireland, Scotland and Wales. University of Manchester. http://documents.manchester.ac.uk/display.aspx?DocID=46558*

[42] *Royal College of Psychiatrists, 2020. Self-harm and suicide in adults: final report of the Patient Safety Group. 2020. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/cr229_self-harm-and-suicide.pdf*

With regards to fulfilling the cost-management role that clustering was supposed to cover, providers will also have to provide patient-level costing information (PLICS) by the same deadline. As well as standardising cost reporting, the use of PLICS is intended to offer a more granular assessment of the relationship between costs and individual provider and patient characteristics.

A broader area in which improvements would further increase the worth of collected and reported data is data sharing. Increased sharing of (and easier access to) care records, for example, would make it easier to ensure that any co-occurring conditions are recognised and taken into account, regardless of which service a patient needs to access. This would make for a more cohesive treatment journey, especially for patients receiving care from multiple services, such as people with comorbidities. In addition, trusts and providers would be better equipped to assess local population health and plan services accordingly. It would also improve efficiency and provide better value by reducing duplication of assessments and tests.

## Improving Access to Psychological Therapies (IAPT)

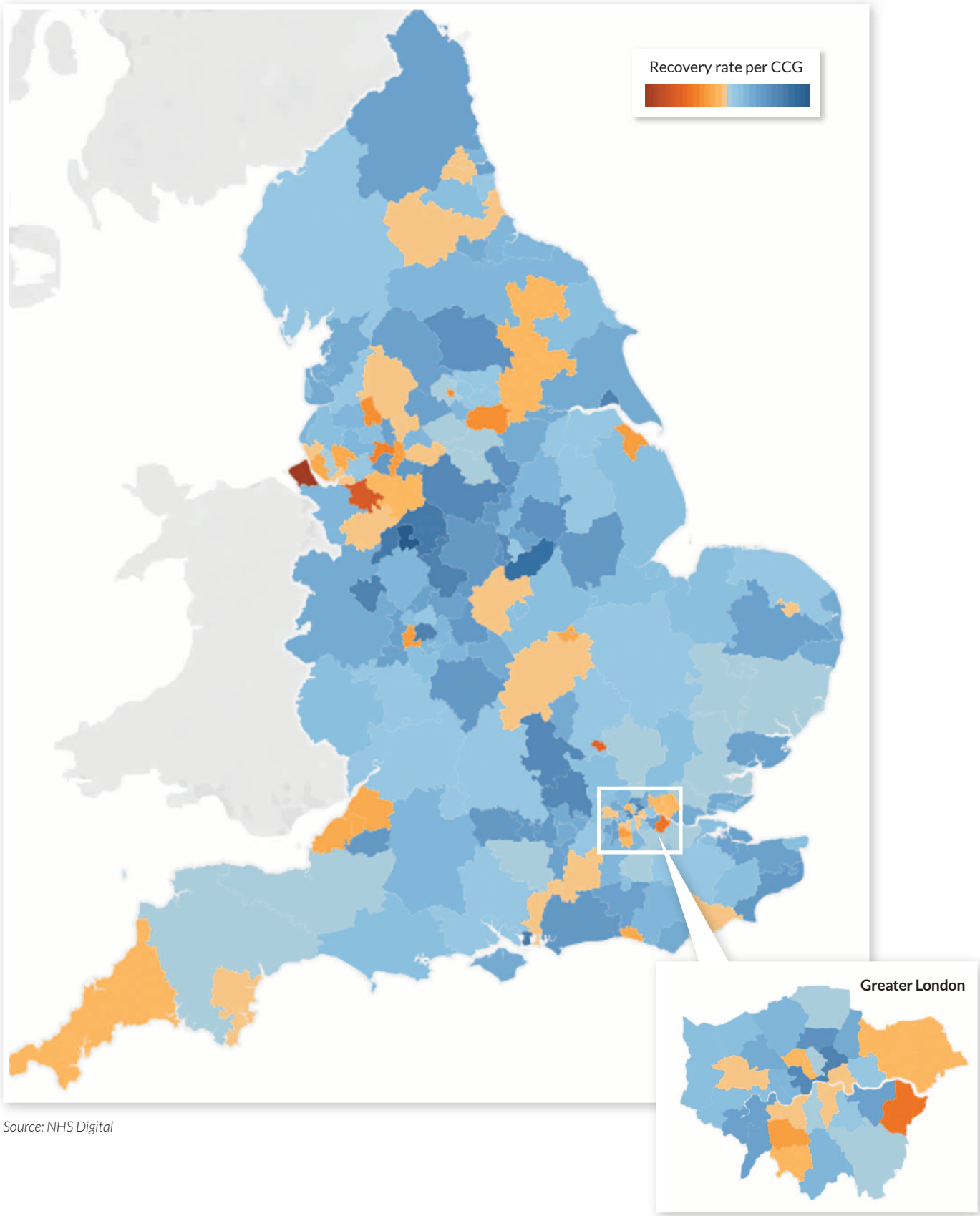
IAPT has been a key contributor to addressing unmet demand in mental health. Established in 2008, the service provides a systematic way to organise and improve delivery of and access to evidence-based psychological therapies for patients affected by common mental disorders such as depression and anxiety disorders.

IAPT has created access to care for over 1 million people each year where none historically existed. More than 50% of patients move towards recovery, and nine out of ten patients attend their first appointment within six weeks of being referred (either by a care professional – often a GP – or via self-referral). Four-week waiting times are being trialled in certain services. Plans set out in the NHS LTP will see the number of people who can access talking therapies reach 1.9 million by 2023/24.[43]

IAPT also publishes data routinely on activity and outcomes. Not only is this an exemplar for other types of mental health services, but it also gives critical information about which needs might be unmet in a given area and hence lead patients to present to SMI services.

[43] *NHS England and NHS Improvement, 2020. Adult Improving Access to Psychological Therapies programme. www.england.nhs.uk/mental-health/adults/iapt/*

*Figure 13: IAPT recovery rates per CCG, 2018/19*




*Source: NHS Digital*

CASE STUDY

## Improving IAPT access for older people

### Surrey and Borders Partnership NHS Foundation Trust

The Bedser Hub at Woking Community Hospital provides integrated health, social care, mental health and voluntary sector services to maintain the independence of older people.

With the aim of improving the access rate to psychological therapies for older people, as well as improving symptoms of depression and anxiety among those accessing IAPT, an 18-month pilot was established at the Bedser Hub in collaboration with Mind Matters, the trust's IAPT service.

#### Face-to-face care and integrated working

A cognitive behavioural psychotherapist was based at the Hub for two days each week, working alongside other clinical professionals in an integrated fashion. Those referred to the service were offered face-to-face assessment before a treatment plan was developed. CBT was offered face-to-face, but telephone sessions were also available.

The pilot was successful (the recovery rate of 60.4% was 10.4 percentage points above the national target), and the service became permanent. The number of referrals kept growing and, in order to follow the stepped care model of IAPT, a psychological wellbeing practitioner later joined the Bedser Hub team to offer assessments and Step 2 Guided Self-help.

As well as increasing access to mental health support for older people, the programme offered an opportunity to reach out to a group that is at increased risk of long-term health conditions. In addition, the programme offered opportunities for integrated working and case discussions between people of different disciplines, potentially creating a more holistic knowledge base through which to develop the care of older people.

## Looking ahead

The factors that increase demand for mental health services are well known. When planning SMI services, robust segmented data on local communities is an essential part of understanding unwarranted variation and responding effectively to it, including by identifying trends to anticipate and plan for changing patterns of need.

For some groups, a range of access barriers can result in demand for services (especially in terms of Route 1) that do not accurately reflect underlying need. Trusts should work with system partners to ensure that this is addressed in needs assessments and the commissioning of services; we have highlighted a range of groups likely to face greater access barriers in our report.

Individual Integrated Care Systems and Primary Care Networks must closely consider these and other vulnerable groups, while taking into account intersectionality. It is important that people categorised as BAME are segmented further when assessment of demand is made, as differing groups within that broad label will have many different needs and issues (as well as some in common). The COVID-19 pandemic has made efforts to identify vulnerable and excluded people all the more important.

## Recommendations

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **1.** Each ICS/STP area should ensure that it understands the needs of the local community and the demand for mental health services, employing Joint Strategic Needs Assessment (JSNA) where appropriate. | **a** Trusts to review local population needs assessments such as JSNA and to take into account factors known to increase mental health needs and demand, including but not limited to the vulnerable groups highlighted in the report to help drive their strategic plans between 2022-2025. | Trusts with support from GIRFT, ICS/STPs, and NHS England and NHS Improvement | For progress within 12 months of publication |
| | **b** Services commissioned to accurately reflect local needs (not just existing demand) to ensure these groups are not being doubly disadvantaged. | | |
| | **c** Trusts to ensure data is segmented to take account of variation in local area needs. | | |
| | **d** Trusts need to work with commissioners to ensure clear information is provided about what is available for local communities, and this is shared and taken into account when estimating demand for trust-provided SMI services. | | |
| | **e** Trusts to co-produce all service developments and redesigns with those who will access such services, will help deliver those services and those affected by those services. | | |
| **2.** Trusts need to work with system partners to ensure that it is clear which needs IAPT services have been commissioned to meet locally. | **a** Ensure that all planning of SMI services takes into account IAPT-commissioned deliverables, outcomes and prevalence. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |
| | **b** Ensure that IAPT services are delivered in line with the IAPT manual, and with NICE guidance on psychological therapies. | | |
| **3.** Trusts need to work with system partners to understand and mitigate increased demand on SMI services related to COVID-19. | **a** Ensure the sustainability of new and/or modified practices such as rollout of 24/7 access lines, and wider use of remote working models and technology established during COVID-19 to improve or assist use of available capacity. | Trusts with support from GIRFT, ICS/STPs, NHS England and Improvement | For progress within 12 months of publication |
| | **b** 24/7 crisis lines to link in to 111 telephone services. | | |
| | **c** Trusts to work with their ICS/PCN and with the relevant national bodies as partners to understand and mitigate the impact of COVID-19 on SMI services. | | |

## Capacity

The overarching aim of NHS mental health services should be to ensure that as many patients as possible enter and successfully pass through Care Route 1 without unnecessary recourse to Route 2 or Route 3. Essentially, no one should lose one day more in the community than is essential for their care and treatment, and anyone needing inpatient care must be able to access the best bed for their needs that day.

There are many factors that impact on capacity in a given geographical area, including historical and current levels of spending (in terms of revenue, capital and infrastructure), and recruitment, retention and deployment of staff. Wider health system capacity will also impact on the ability of services to make the best use of SMI capacity.

Paying close attention to the linkages and dependencies that exist between different levels of care and the individual part of the wider health and social care system is essential to ensuring that trusts have the capacity to provide all patients with timely and appropriate access. Patients must also be able to move between different levels of care intensity (in both directions), as well as being able to enter and exit the service with minimum difficulty. If all the constituent parts are operating efficiently and in concert with each other, patients will access appropriate care and not become stranded, thus maximising total capacity.

Despite large amounts of information being collected about people accessing services, there are major issues with using this data to best understand and make use of available capacity. Although focusing on individual team types can be important in ensuring that the right skills are available, doing so can also hamper attempts to look how specific skills can be best used across the whole pathway.

A focus in the NHS LTP on the transformation of community services includes a move from viewing services in terms of team types to identifying which interventions and which intensity of service are needed for any given person at any given time. This offers a significant opportunity to take a more holistic view of capacity – as long as it ensures equitable access across all sections of the community. It is a key recommendation of this report that this transformation be dependent on more robust, timely and accessible data analysis and reporting.

While it has been a major achievement of mental health providers not to exceed budgets, this has yielded reduced capacity in SMI services. Significant issues have negatively impacted the balance between reducing expenditure historically spent on inpatient beds and funding improved community services. Too often the impact has resulted in cost reduction rather than cost improvement or cost efficiency.

Data clearly shows an overall reduction in acute mental health bed capacity for adults and older adults over a number of years. Partly, this is because the evolution of mental health services in recent years (notably including the expansion of IAPT) has seen funding focused in areas that would previously have been covered by core CMHT services or would have manifested as unmet need. New funding has gone into dedicated services such as perinatal care, acute hospital liaison and older people's mental health – all of which have benefitted from investment. For example, data shows that the decline in beds for older people is not linked to out of area placements – instead, it is partly because services have developed better ways of treating the mental health needs of older patients.

Overall, however, not all savings arising from bed reductions can be tracked into investment in community services, and at least some funds have flowed out of mental health into other services, to the detriment of community care. A 2019 impact report that assessed progress on the implementation of NICE mental health guidance acknowledged advances in mental health provision, but it also highlighted ongoing problems with access to psychiatric therapy for people with SMI, as well as shortcomings in community care; the report deemed the latter responsible for too many people reaching crisis before receiving the correct care for their needs.[44]

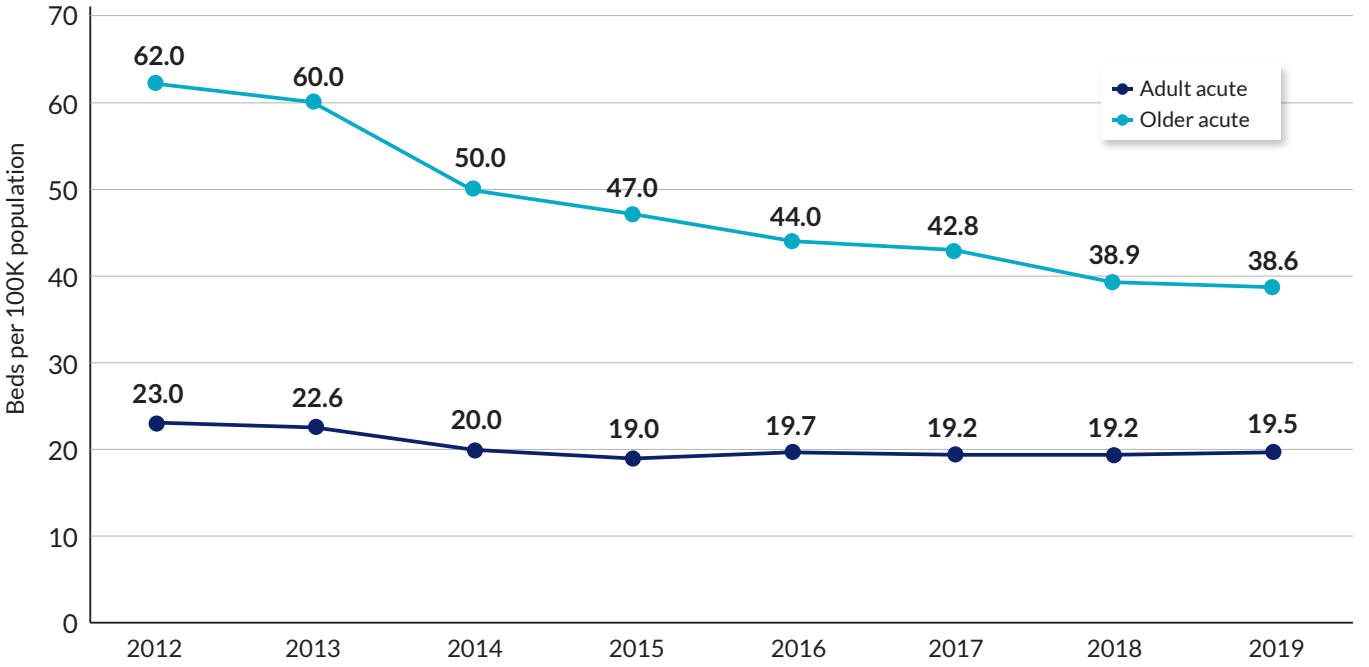
Between April 2014 and March 2019 community caseloads per 100K registered population reduced, with a 12.3% reduction in older adult services and adults of working age services by 2017/18, before a recovery in 2018/19. As noted above, the reorientation of some community care represented by the expansion of IAPT and dedicated services such as perinatal care does mean that some of the reduction in core community caseloads over the past five years is likely to be explained by increased coverage in those areas (which are not covered by the scope of this report). Similar declines were recorded in community contacts.

NHSBN data for 2018/19 shows that although only 6% of the 1.6 million people accessing SMI care receive inpatient treatment, about half of trusts still invest more in inpatient care, partly reflecting higher costs associated with inpatient services.

Compounding all of this, the sector's lack of routinely reported outcome measures – against which cost optimisation programmes could be judged – is a self-imposed impediment.

[44] *NICE, 2019. NiceImpact Mental Health. www.nice.org.uk/media/default/about/what-we-do/into-practice/measuring-uptake/niceimpact-mental-health.pdf*

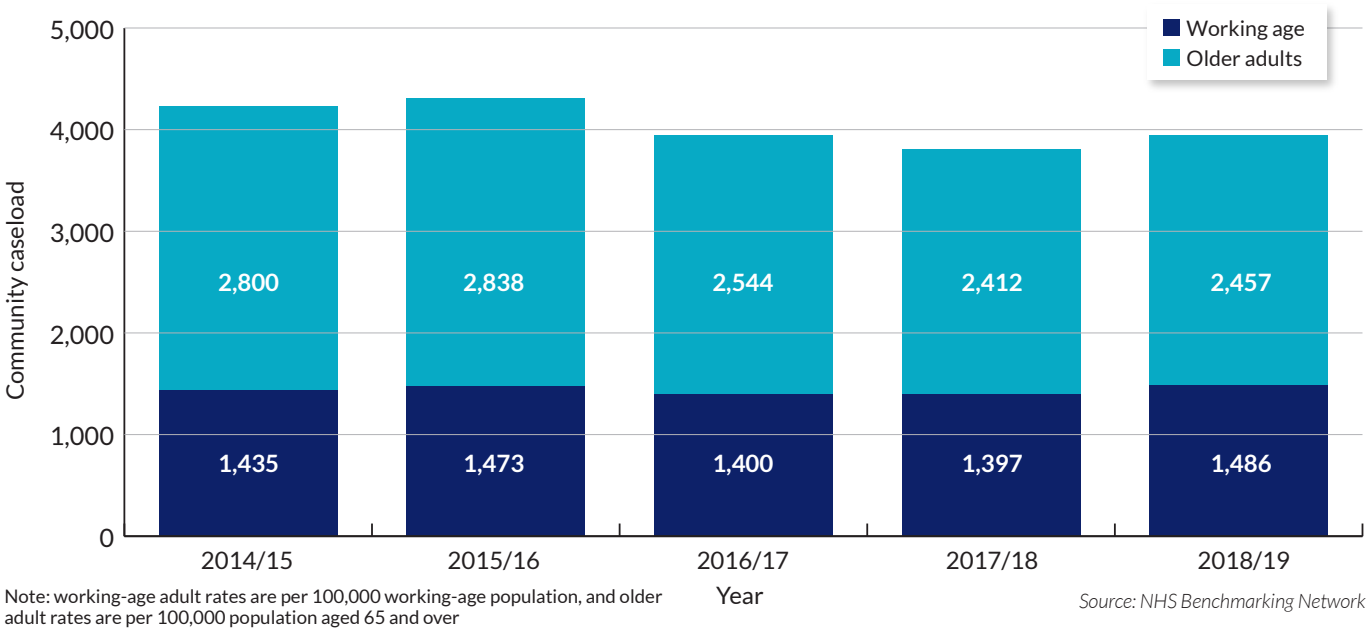
*Figure 14: Inpatient beds per 100,000 population, April 2012–March 2019*




Note: working-age adult rates are per 100,000 working-age population, and older adult rates are per 100,000 population aged 65 and over

*Source: NHS Benchmarking Network*

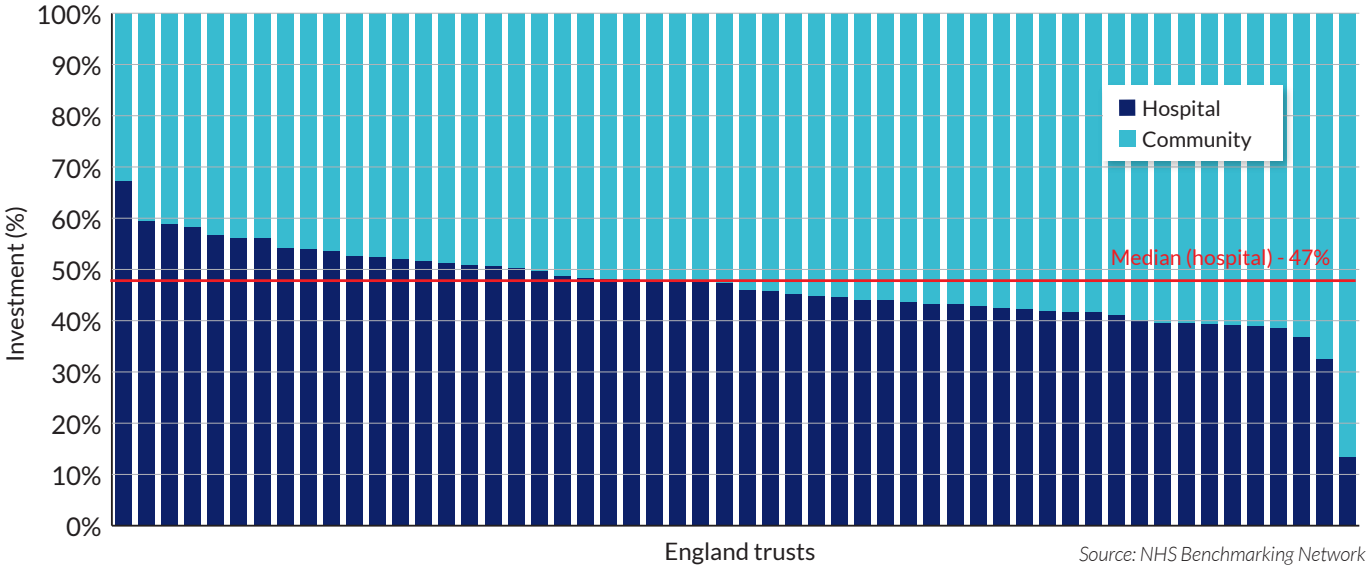
*Figure 15: Community caseload per 100,000 population, April 2014–March 2019*




Note: working-age adult rates are per 100,000 working-age population, and older adult rates are per 100,000 population aged 65 and over

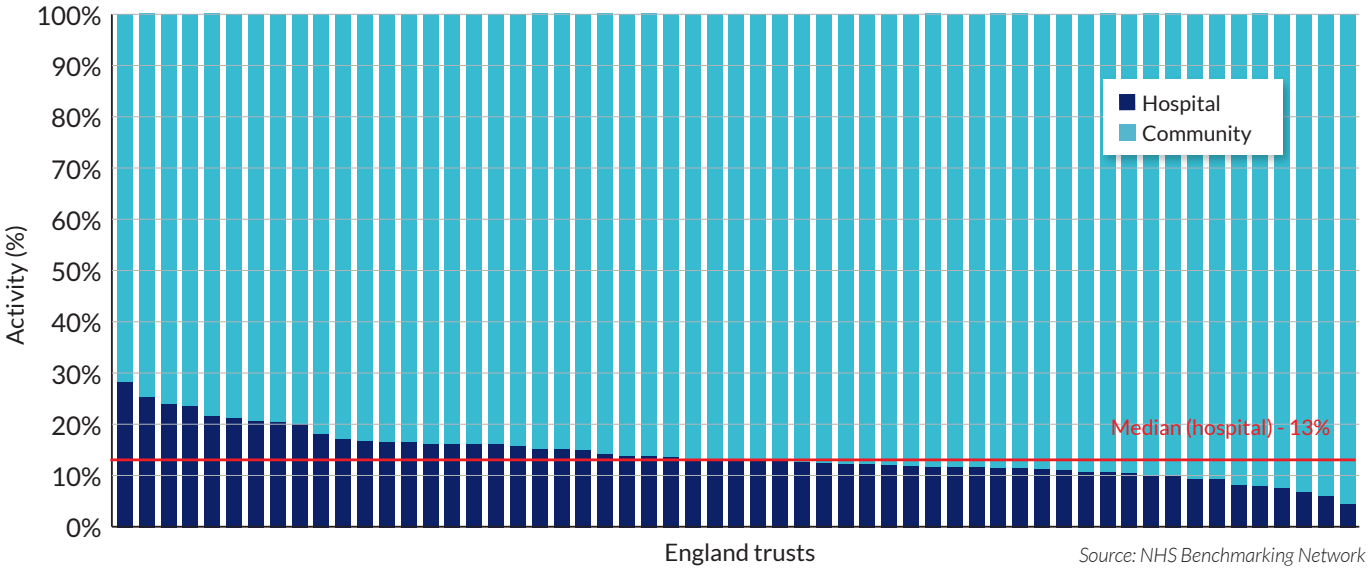
*Source: NHS Benchmarking Network*

*Figure 16: Balance of financial investment, 2018/19*




*Source: NHS Benchmarking Network*

*Figure 17: Balance of activity, 2018/19*




*Source: NHS Benchmarking Network*

## Community care and home treatment

Although expansion of community mental health services has been notable over the past two decades, the reduction in core capacity in recent years has left resources stretched at a time when demand has risen.

Community services play a key role in supporting people to manage mental health conditions, and problems with community service capacity can create significant pressures on acute and crisis services. CMHTs and associated specialist services such as EIP rely on multidisciplinary teams to provide services for people with serious mental illness.

This is a necessarily complex staffing mix, and one that needs properly resourcing as the move to focus more closely on community provision continues. The NHS LTP targets the addition of 10,880 staff to work in community care for SMI. In its latest State of Care Report, the CQC cites a slight decline in the total numbers of mental health nursing staff and a sharper decline in inpatient mental health nurses, with feedback suggesting that community services continue to face staff shortages. As such, the expansion in community SMI staffing included in the NHS LTP is welcome.[45]

The value of well-resourced community mental health care is clear. Part of the reason that investment in inpatient services is still relatively high is that inpatient care is much more expensive than community-based care.

Historically, though, too often reduction in mental health beds has been a financial balancing exercise for the whole healthcare system, with the savings not fully invested in expanding community mental health care. A lack of community services directly contributes to increased admissions and delays in discharges – and, hence, bed pressures, including use of out of area acute beds.

***Table 6: Costs per service type, 2018/19***

| Metric | England | | |
|---|---|---|---|
| | Median | Range | N providers |
| Adult acute cost per bed | £143,331 | £98,573 and £191,248 | 93% (54/58) |
| Older adult cost per bed | £156,164 | £69,689 and £331,176 | 93% (54/58) |
| Generic CMHT cost per patient on the caseload | £2,164 | £1,150 and £5,625 | 93% (54/58) |

*Source: NHS Benchmarking Network*

The table above showing median service costs and ranges shows significant variation in spending on a per bed and per patient basis. This data is subject to significant issues around data quality and cost allocation. There will be some warranted variation – for example, smaller, more isolated units will cost more to run, while communities and different ward types will require differing types of skill mix to meet their needs.

We are unable, given currently available data, to provide an optimum level of investment per bed day or per community case, or even say where in those ranges each number is likely to fall; however, lower costs tend to be associated with lower skill mix and higher caseloads, which makes providing optimum care and treatment more difficult. The average cost per community case in England is lower than the average for the UK (£2,164 versus £3,294).

Continued investment in community services is needed to help people receive the best care and treatment, which will also have the knock-on impact of reducing bed use and freeing up inpatient capacity for those who most need it. Data shows that upwards of 60% of referrals to CMHTs are rejected by a small number of trusts. We suggest that serious systemic issues are indicated when more than 10% of referrals are not being accepted.

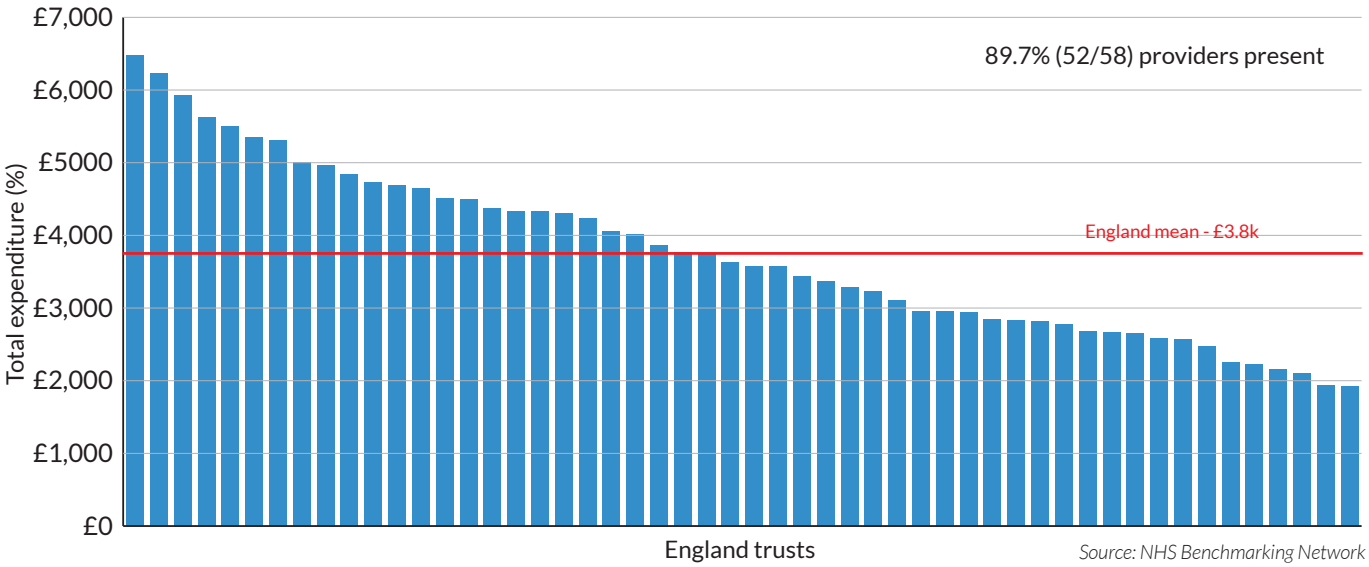
An elevated level of unaccepted referrals indicates clear unmet demand. Those who are affected face added distress and lost time, while services face inefficiencies in terms of teams spending time on referrals that will not be accepted. Unaccepted referrals also increase the chances of people presenting through Route 2 and Route 3.

[45] *Care Quality Commission, 2020. State of Care 2019/20. www.cqc.org.uk/publications/major-report/state-care*

We are not able to say where in the system the issue lies, but it indicates a clear mismatch between the need perceived by the referrer and the capacity of the mental health team to address that need. A lack of clarity about local access pathways may also be a barrier to the use of other locally available health or care services that meet certain needs. The NHS Five Year Forward View, published in 2014 to plan the development of NHS services over the subsequent five years, started work on tackling these issues, and this has since been picked up and enhanced by the NHS LTP.[46]

NHS England and NHS Improvement has recently completed allocation of targeted additional investment of £261m in community-based crisis teams and 'crisis alternatives'. This represents a welcome expansion of community-based crisis care, as well as being in line with the innovative pilot work being done through the NHS LTP to identify and improve best practice.

***Figure 18: Total expenditure per patient in contact with community mental health services, 2018/19***




*Source: NHS Benchmarking Network*

## Inpatient capacity

When patients are referred to inpatient care, bed capacity tends to be limited, with occupancy frequently running higher than the 85% rate recommended by the Royal College of Psychiatrists. One consequence of this is that some patients are not able to access inpatient care in a timely manner because a bed is not available. Although the majority of people are admitted to an appropriate local bed, some have to go out of area for at least part of their inpatient admission.

The consequences of limits to inpatient capacity can be fatal. Although most deaths by suicide involve people not in contact with mental health services (1,517 of a total of 18,024 suicides involved people under mental health care in the UK in 2017 – and the proportion has been falling in recent years), coroners have brought to NHS attention a number of deaths involving people who were not admitted to inpatient care owing to the apparent lack of a local bed.[47]

Such 'turn-aways', when caused by issues with system flow and capacity issues, should not occur – if a person requires inpatient admission, they should be found and supported in the best bed available until a more appropriate one becomes available. The lack of availability of a mental health bed is one of the most common reasons for patients waiting longer than 12 hours in A&E from decision to admit to transfer to inpatient bed.

[46] *NHS England, 2014. NHS Five Year Forward View. www.england.nhs.uk/publication/nhs-five-year-forward-view/*

[47] *The National Confidential Inquiry into Suicide and Safety in Mental Health, 2019. Annual Report: England, Northern Ireland, Scotland and Wales. University of Manchester. http://documents.manchester.ac.uk/display.aspx?DocID=46558*

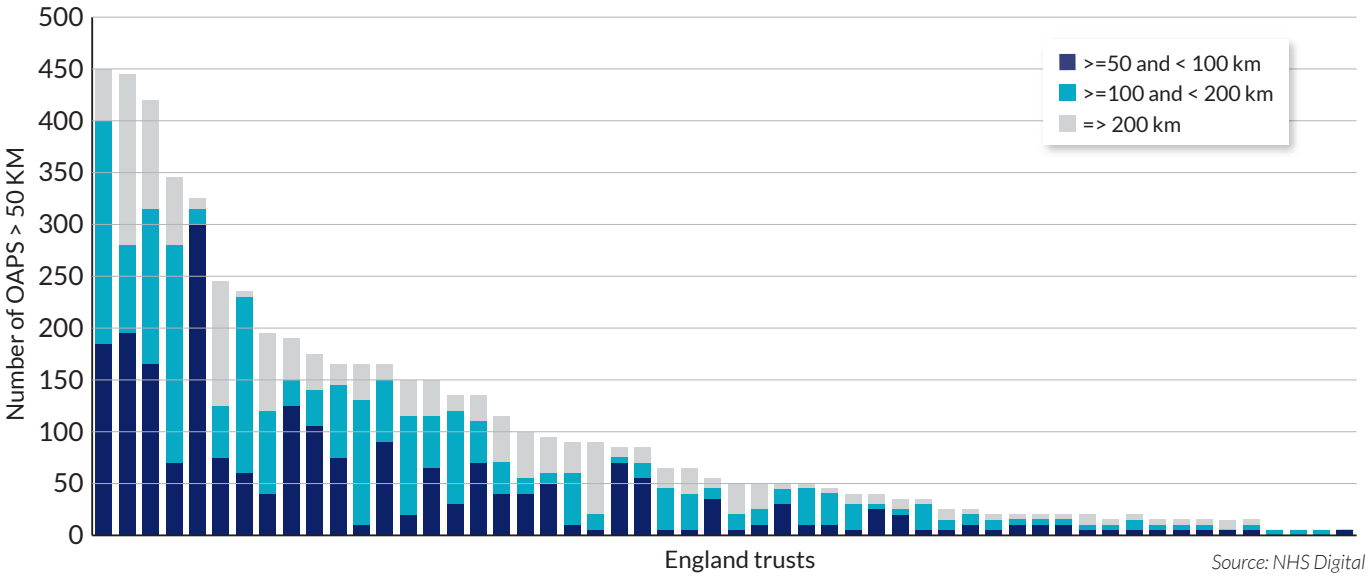
## Out-of-area placements

Limitations in community-based care and inpatient capacity can drive a reliance on out of area placements (OAPs), which are costly and can have a detrimental impact on care. Although the NHS LTP mandates the ending of OAPs by March 2021, their numbers remain high in some trusts. The aim of the NHS LTP is to ensure that patients are admitted to the best available bed when essential.

In 2018/19 the range of out of area bed usage by trusts varied enormously, with some having zero or very few OAPs, while some reported more than 100. Overall, 8.5% of the 100,998 total inpatient admissions resulted in OAPs that year. In some cases, people were sent long distances to an available bed.

Sending patients long distances to receive care can make it very difficult for family and friends to visit and maintain regular contact. It can also make a patient's transition back to their own community more complex and can (but should not) lead to less contact and input to their care and discharge planning from their local CMHT.

***Figure 19: Out-of-area placements of more than 50km travelled, 2018/19***




*Source: NHS Digital*

Although the use of OAPs is relatively high in some trusts, there is great variation, with almost half of the 57 trusts surveyed by GIRFT reporting 50 or less OAPs of 50km or more in 2018/19. There is no correlation between use of OAPs and local bed numbers, meaning that the latter is not a key explanatory variable in out of area bed use. The issues therefore relate to flow issues across the whole system, including available community capacity. Where OAP numbers are low, coherence and good practice across services in specific trusts may offer lessons to other providers.

## Workforce

There is wide variation in recruitment and retention in NHS mental health services. For example, although overall staff turnover is largely similar at a national level in community care, CRHT services and inpatient care, on a trust-by-trust level turnover ranges from 5% to 33% in community care, from 2% to 27% in CRHT and from 4% to 23% in inpatient care. Employment data for inpatient care also reveals both a high overall reliance on bank and agency staff and a huge variation at trust level, ranging from 6% of overall costs to 28%.

*Table 7: Baseline capacity indicators, 2018/19*

| Indicators | England (range where appropriate) | England per 100K weighted population (range) | N providers |
|---|---|---|---|
| Community staff in post | 37,437 | 64.6 (33.1–120.3) | 96.6% (56/58) |
| Community staff vacancies | 2,524 | 5.2 (1.2–17.4) | 81.0% (47/58) |
| Community staff sickness rate | 5% (1–15%) | - | 87.9% (51/58) |
| Community staff turnover | 11.7% (5–33%) | - | 87.9% (51/58) |
| Total EIP staff | 259.7 | 7.6 (2.3–24.0) | 81.0% (47/58) |
| Total CRHT staff | 5,760 | 14.7 (3.2–35.9) | 91.4% (53/58) |
| CRHT staff vacancies | 475 | 1.4 (0.1–5.9) | 70.7% (41/58) |
| CRHT staff sickness rate | 5.7% (3.3–15.9%) | - | 81.0% (47/58) |
| CRHT staff turnover | 10.7% (2.0–27.0%) | - | 81.0% (47/58) |
| Adult acute inpatient beds | - | 20.0 (10.9–46.8) | 96.6% (56/58) |
| Older adult inpatient beds | - | 29.0 (7.8–49.8) | 96.6% (56/58) |
| Adult inpatient staff in post | 13,598 | 35.3 (16.4–61.3) | 91.4% (53/58) |
| Adult inpatient bank and agency costs | £154,674,993 | - | 91.4% (53/58) |
| Adult inpatient bank and agency costs as a % of overall inpatient costs | 15.2% (6.1%–28.2%) | - | 91.4% (53/58) |
| Adult inpatient clinical staff vacancies | 1,705 | 15.2% (6.1–28.2%) | 79.3% (46/58) |
| Adult inpatient staff sickness rate | 6.1% (3.0–15.0%) | - | 89.7% (52/58) |
| Adult inpatient staff turnover | 12.2% (4.0–23.2%) | - | 89.7% (52/58) |

*Source: NHS Benchmarking Network*

Workforce shortages in mental health affect staff workload, wellbeing and morale, ultimately affecting patient outcomes and future recruitment and retention efforts. They also impact negatively on continuity of care, which is even more critical when interventions and conditions are longer term, as is common in mental health.

The NHS LTP, like the Five-Year Forward View before it, sets ambitious targets for the expansion of the mental health workforce. A further 27,000 staff will be recruited by 2023/24, including 1,540 nurses, 750 psychologists and 530 admin staff (as part of a 10,880-person expansion) in adult SMI community care. There is also a broad expansion of support to clinical staff in SMI community care and inpatient care. The NHS LTP also suggests utilising physician associates and nursing associates to relieve workforce pressures.[48,49]

[48] *Royal College of Psychiatrists, 2019. Physician Associates Working in Mental Health. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/physician-associates-working-in-mental-health.pdf*

[49] *Health Education England, 2019. New Roles in Mental Health Nursing Associate Task & Finish Group Supporting the mental health workstream. www.hee.nhs.uk/sites/default/files/documents/Nursing%20Associate%20Report%20March%202019.pdf*

***Table 8: Summary of NHS LTP indicative workforce requirements***

| | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|---|
| Adult common mental illnesses (IAPT) | 0 | 0 | 1,000 | 1,980 | 2,940 |
| Adult SMI community care | 650 | 2,180 | 3,720 | 7,570 | 10,880 |
| Adult liaison mental health | 0 | 0 | 110 | 180 | 250 |
| Adult crisis alternatives | 400 | 810 | 1,210 | 1,610 | 2,010 |
| Therapeutic acute mental health inpatient care | 0 | 110 | 230 | 450 | 760 |

*Source: NHS Long Term Plan*

Mental health workforce numbers began to increase in 2017 after a sustained period of decline. They now need to keep pace with both the targets of the NHS LTP and the likely additional demand (and strain on the workforce) linked to COVID-19. To support the care of older people with mental health problems (which is not specifically covered in the workforce expansion contained in the NHS LTP), in April 2020 HEE published the Older People's Mental Health Competency Framework.[50]

There are concerns that recruitment will not be able to keep pace with demand. NHS data shows that the hospital and community health services mental health workforce has grown only slowly over the past ten years, with declines in some areas (nursing being one example, although numbers have begun to increase more recently).[51]

## Psychiatry

A 2017 Centre for Mental Health report highlights issues with psychiatry staffing levels. The report states that attrition levels among psychiatrists are higher than for NHS consultants generally, while a high number of new recruits (around a fifth in 2014) do not complete their training.[52] While the number of consultants working in general psychiatry rose by 14% between April 2015 and April 2020, the number of their counterparts working in old-age psychiatry declined by 3.5%.[53]

There is also significant regional variation in psychiatrist numbers, with the number of consultant psychiatrists ranging from roughly 6 per 100,000 to 12 per 100,000 depending in region.[54] Regional variation in training posts may be one factor – there is a trend among doctors to remain where they have trained, which raises the risk that areas with lower amounts of training posts will have reduced psychiatrist numbers in the long term.

Difficulties with recruiting and training doctors to work in psychiatry open the specialism to workforce vulnerabilities. For example, trusts are disproportionately dependent on recruiting overseas staff, which makes services vulnerable to any decline in the attractiveness of roles in England. This has been an issue in other areas, such as through increased departures from the NHS of nurses originating from EU and EEA countries in recent years.[55]

[50] *Health Education England, 2020. Older People's Mental Health Competency Framework. www.e-lfh.org.uk/wp-content/uploads/2020/04/Older-Peoples-Mental-Health-Competency-Framework-INTERIMV1.2.pdf*

[51] *NHS Digital, 2020. NHS Workforce Statistics – Hospital and Community Health Services mental health workforce interactive data report. https://app.powerbi.com/view?r=eyJrIjoiZWQ4YzM3M2QtZmYxYS00MGJhLWFkNWMtMWFmMGVlNmZmNDBiIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9*

[52] *Centre for Mental health, 2017. The Future of the Mental Health Workforce. www.centreformentalhealth.org.uk/sites/default/files/2018-09/CentreforMentalHealth_Future_mental_health_workforce.pdf*

[53] *NHS Digital, 2020. NHS hospital and community health service (HCHS) monthly workforce statistics. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics*

[54] *Centre for Workforce Intelligence, 2014. In-depth review of the psychiatrist workforce. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507557/CfWI_Psychiatrist_in-depth_review.pdf*

[55] *Nursing and Midwifery Council, 2019. Nursing and midwifery numbers at all-time high but workforce pressures remain, finds NMC. www.nmc.org.uk/news/press-releases/nmc-register-data-march-2019/*

## Nursing

Workforce trends in mental health nursing have shifted in recent years. Although mental health nursing numbers are significantly lower overall than ten years ago, between April 2015 and April 2020 the total number of mental health nurses increased by 3%.[56] As part of this overall increase, the number of community mental health nurses increased by almost 23%, while the number in the 'other nurses' category, which includes those working in inpatient care, fell by about 10%. Despite the recent overall increase in mental health nursing staff numbers, vacancy rates have increased in the past year and remain higher than for nursing overall. They also vary significantly according to region.

***Table 9: Registered nurse vacancy rates by region***

| Region | Sector | 2018/19 Q4 | 2019/20 Q4 |
|---|---|---|---|
| East of England | Mental Health | 14.9% | 15.9% |
| | All nursing | 11.6% | 9.3% |
| London | Mental Health | 17.0% | 18.6% |
| | All nursing | 14.1% | 13.1% |
| Midlands | Mental Health | 11.9% | 12.0% |
| | All nursing | 11.0% | 10.9% |
| North East and Yorkshire | Mental Health | 8.8% | 10.8% |
| | All nursing | 7.8% | 8.1% |
| North West | Mental Health | 10.2% | 10.8% |
| | All nursing | 10.2% | 8.7% |
| South East | Mental Health | 13.7% | 13.9% |
| | All nursing | 12.7% | 9.9% |
| South West | Mental Health | 11.7% | 10.4% |
| | All nursing | 9.5% | 7.2% |
| **National average** | **Mental health** | **12.6%** | **13.2%** |
| | **All nursing** | **11.1%** | **9.9%** |

*Source: NHS Digital*

## AHPs and psychology

Numerically, nurses are clearly the biggest group in the mental health workforce, but when teams have low numbers of posts for other roles, such as allied health professionals and psychologists, a single vacant post may represent the loss of a high proportion of that skillset.

According to the Centre for Mental Health, the number of full-time staff working within clinical psychology roles increased from 6,797 in 2009 to 7,057 in 2016. In addition, the numbers of psychotherapists and assistant practitioners also increased. However, the numbers of trainees and students reduced over the same period, from 1,832 to 1,305.[57]

[56] *NHS Digital, 2020. NHS hospital and community health service (HCHS) monthly workforce statistics. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics*

[57] *Centre for Mental Health, 2017. The Future of the Mental Health Workforce. www.nhsconfed.org/-/media/Confederation/Files/Publications/CentreforMentalHealth_Future_mental_health_workforce.pdf*

The NHS LTP plans broad expansions in the numbers of both psychologists (an extra 2,520 by 2023/24) and psychotherapists (an extra 5,610 psychotherapists and psychological professionals). An extra 470 occupational therapist and 580 paramedic roles are also allotted for recruitment to work in mental health services. In addition, one goal in relation to crisis liaison is 100% roll-out of mental health professionals working in ambulance control rooms. The NHS LTP also includes provision for the expansion of mental health pharmacy: there is scope to create 260 new pharmacist posts in adult SMI care by 2023/24.

A recent HEE report assesses the barriers and support available to social workers who seek to become approved mental health professionals (AMHPs) and approved clinicians.[58] The report highlights the need for greater support from within trusts and mental health services for those looking to move into AMHP and approved clinician roles. The report also suggests that pay and conditions are poor, while recruitment, development, retention and demographic issues affect the role. More positively, the report highlights the advent of university courses providing qualifications for dual-qualified nursing and social work roles, as well as detailing transformative new approaches to mental health social work, forensic social work, trauma and family-based social work, leadership, and continuous professional development.

## Sustainable recruitment

Recruitment must be maximised and sustainable – people must be attracted to jobs and then encouraged to continue working in services. More defined career structures are identified by the British Medical Association as one way of offering new recruits a vision of a future within the service, particularly in nursing. Mentoring and supervision have been undervalued in mental health care, despite offering ongoing opportunities to nurture and develop staff. One example of good practice is a concerted campaign in recent years by the Royal College of Psychiatrists, which has done an excellent job of raising the fill rate for trainee psychiatrists to almost 100%.[59]

One issue relates to how people regard work in mental health care. Stigma towards mental illness has historically led to work in mental health being seen as less important than work in physical health. The reality is that the wide collection of conditions and syndromes that fall within the broad heading of SMI in the NHS LTP can, if not appropriately treated, cause equally serious levels of life-changing and life-shortening damage as physical health conditions. Mental health conditions also show a similar pattern of multifactorial predisposing, precipitating and perpetuating factors, and are as amenable to effective interventions, care and treatment as physical health conditions. The fact that this reality is still not readily accepted is something that should be considered as part of wider moves to reach parity of esteem between mental and physical health.

Another issue in relation to sustainable workforce practice is the management of the psychological and physical stresses faced by those working in mental health provision (and all other forms of healthcare). Providing care amid the rapidly changing, high-demand environment brought about by the COVID-19 pandemic may have elevated psychological and physical stress levels among health workers. NICE provides guidance on improving employee physical and mental health, adherence to which is mandated in the Health and Social Care Act.[60]

[58] *Health Education England, 2020. Transforming mental health social work. www.hee.nhs.uk/sites/default/files/documents/Transforming%20MHSW%20Conference%20Report.pdf*

[59] *Royal College of Psychiatrists, 2020. Another strong year for psychiatric recruitment. www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/07/21/statement-on-near-100-fill-rate-for-psychiatric-trainees*

[60] *NICE, 2017. Healthy workplaces: improving employee mental and physical health and wellbeing. www.nice.org.uk/guidance/qs147/chapter/Quality-statement-1-Making-health-and-wellbeing-an-organisational-priority*

CASE STUDY

## Working to recruit more student nurses locally

### Leeds and York Partnership NHS Foundation Trust

Although large numbers of student nurses were being trained locally and on placement in Leeds and York Partnership Foundation Trust (LYPFT), on average only half of these students came to work for the trust as registered nurses. At the same time, the trust had large numbers of mental health nursing vacancies.

To improve outreach to local nursing students and reduce nursing vacancies, several bodies work within LYPFT to manage the outreach, employment and retention process:

- A Recruitment and Retention Group oversees professionally qualified vacancies and related workstreams.
- A Practice, Learning and Development Team works in partnership with local universities to plan for future workforce needs.
- A Non-Medical Education Committee identifies training needs and how these can be met.
- A Workforce and Development Team develops a robust training needs analysis specific to service area.

The trust offers a guaranteed position as a nurse to any trainee that it has signed off. Every student is also invited to engage in a career conversation to identify their preferred position. In addition, the trust supports some nursing associates to complete Nursing Degree Apprenticeships. LYPFT is also developing internship and mentorship programmes to raise its profile as an employer.

#### Results

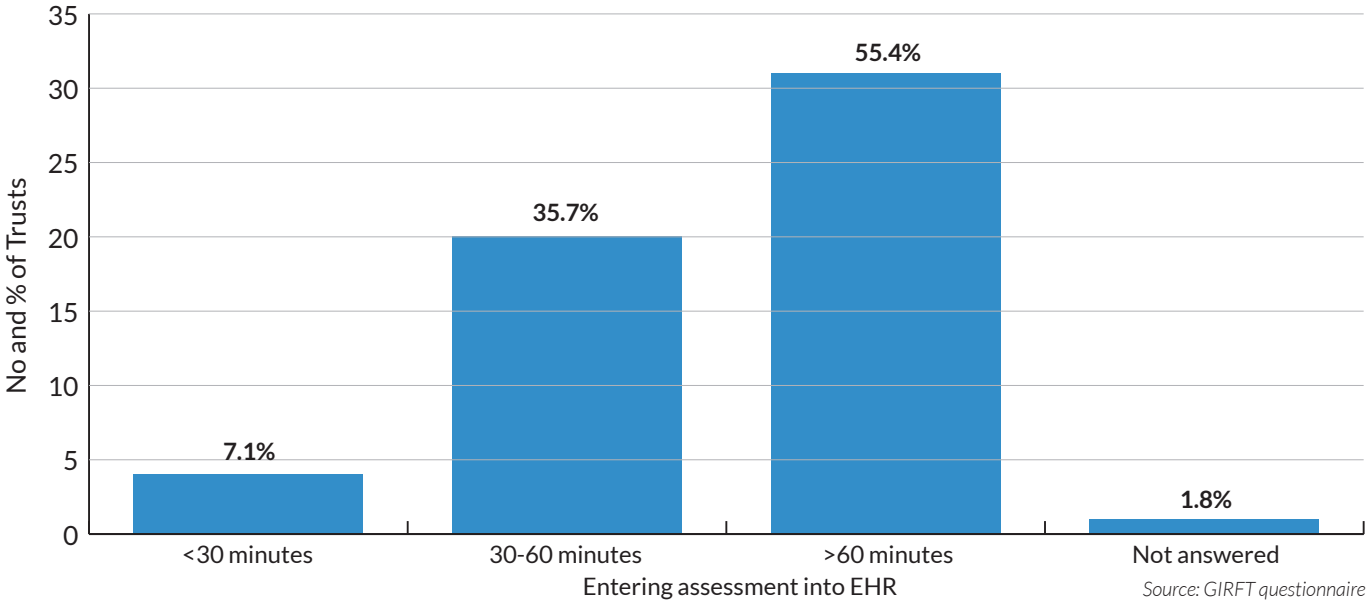
More than 80% of nursing students studying at local universities have moved into nursing posts at LYPFT during the two years that the programme has been running. This has had a significant impact on vacancies. It also means that most new nurses are experienced in the trust's clinical settings, familiar with its policies and procedures, and have already completed some mandatory training. At the time of writing, the trust has just offered jobs to all 95 students due to qualify next year, while ten newly qualified nursing associates have also just been employed.

## Utilisation of workforce and resources

In addition to variation in recruitment and staff retention, there is variation in how the workforce is utilised, and questions exist over whether the NHS is making best use of the staff that it has. One area where efficiency gains could be made within mental health services is administrative work. At present, such work can take up clinician time that could be better used to provide care and treatment.

For example, when asked in the GIRFT questionnaire how long it takes clinicians to input an assessment on the computer, more than half of respondents said that this takes over an hour (this varied greatly between trusts, from less than 30 minutes to over 90). Furthermore, almost 80% of new patient assessments are entered by clinicians unassisted. In short, some clinicians are spending more time completing data entry tasks than they are conducting assessments. In a context of major systemic workforce shortages, this is clearly far from the best use of clinician time.

***Figure 20: GIRFT questionnaire: "How long does it take to enter a new assessment into your Electronic Health Record?"***




*Source: GIRFT questionnaire*

In terms of reducing the time that clinicians spend on administrative tasks such as data entry, making use of the NHS LTP's plan for broad recruitment of clinical support staff across community and inpatient care may offer one solution. Some trusts have already implemented other efficiency-saving measures, such as the use of typing pools to input assessments. Voice dictation software may also help clinicians to free up time spent on administrative tasks.

Generally speaking, upgrades to hardware and software used for data entry would speed up data entry and improve accessibility of recorded data. Given that timely access to relevant information is critical to effective care provision, improving the IT infrastructure and functionality of systems to ease input and timely accurate retrieval of information has to be a key capital priority to improve mental health services. Spending hours inputting and retrieving vital information should never be accepted as a 'normal' part of a clinician's workload.

The Topol Review, published by Health Education England in 2019, explores how technology will impact on healthcare and the heath workforce. A follow-up report presents a review of the technologies that might help to transform mental healthcare over the next 20 years.[61]

[61] *Health Education England, 2019. The digital future of mental healthcare and its workforce: a report on a mental health stakeholder engagement to inform the Topol Review. https://topol.hee.nhs.uk/wp-content/uploads/HEE-Topol-Review-Mental-health-paper.pdf*

CASE STUDY

## Providing real-time caseload information

### Southern Health NHS Foundation Trust

Southern Health adopted the use of Tableau, a data visualisation platform used in business management. The aim was to provide clinical staff with a synopsis of the current state of the patients allocated to their team. This is designed to help highlight where elements of the prescribed clinical pathway have not been delivered or where potential gaps or errors in the record-keeping process could impact on future care delivery.

#### Making analytics easy to access

The data is available to clinical and operational staff via an online server. Tableau provides clinicians with the ability to perform searches as well as save preferences in regard to a specific team or individual clinical caseload. Furthermore, users can establish e-mail subscriptions that deliver relevant analytics directly to their inboxes.

Ninety percent of users state that Tableau has increased their ability to improve the way that they and their team work, and 82% feel that Tableau has facilitated improvements to the way that the trust values them and recognises positive performance.

The implementation of Tableau has also improved compliance with a number of key compliance and safety indicators. For example, the ability that teams have to audit their caseloads has reduced the number of patients appearing on caseload without having had any recent contact. This stands at just 0.1% for community mental health teams, significantly lower than previously.

## Data issues and workforce planning

As with the other areas covered in this report, there are issues with how data is recorded and used for workforce planning. In GIRFT deep dives, data quality in this area was widely described as poor. Common data-related issues around staffing and skill mix include reporting of basics such as capture of staff numbers in each discipline though to what staff actually do in different types of teams. There is also much duplication of data recording, which results in unnecessary use of scarce resource and creates uncertainty in terms of which data can be relied upon.

Even in terms of the target figures included in the NHS LTP, these are only indicative. As local people plans are developed, a clearer picture should emerge of specific recruitment targets for each provider – but this will rely on efficient recording and use of workforce data.

## COVID-19 and capacity

The response to COVID-19 has accelerated moves to meet some capacity-related targets. For example, plans to establish 24-hour access to a crisis line from March 2021 were brought forward and met in April 2020. With pressure on mental health services likely to increase as the immediate and longer-term impact of COVID-19 becomes apparent, trusts and providers will need to work hard to ensure that crisis services are able to continue to implement sustainable new measures while meeting demand.

If this is achieved successfully, patients are more likely to receive effective care and treatment in a timely way, limiting the potential for patients to be left in distress and end up in Routes 2 or 3. Delivery of the NHS LTP funding – alongside increased capacity and effective timely interventions in core community mental health services, backed up by access to the 24-hour crisis and home treatment services when needed – is vital to this. It remains to be seen if the impact of COVID-19 on demand and capacity (including on system partners) may make delivery of the NHS LTP target of zero out-of-area acute bed usage more difficult to attain.

CASE STUDY

## Adapting crisis response in the face of COVID-19

### Cambridgeshire and Peterborough NHS Foundation Trust First Response Service

Throughout the COVID-19 pandemic, the number of first-time contacts with mental health services in Cambridgeshire and Peterborough has increased, alongside an increase in complexity and acuity of those presenting to the service. In response, the trust moved to modify its First Response Service, an existing service for people in crisis that provides 24-hour access to mental health care and support.

The key change was the development of a 'consultant' list at the start of lockdown. This means that every person who has a face-to-face or video consultation has their case reviewed by a member of the senior leadership team to ensure that appropriate actions have been taken regarding issues such as onward referrals and safeguarding.

This enabled the team to be able to review and reflect on cases seen during a particularly stressful and unknown period in crisis mental health care.

#### Short and long-term benefits

As a result of the consultant list and the review of virtual and face-to-face contacts, a serious safeguarding incident was highlighted, and actions were taken to ensure safety.

More broadly, the modifications to the First Response Service already look to be yielding longer-term improvements. For example, staff have been able to get feedback on their assessments and the trust has used the reviews to highlight and share areas of good practice.

## Looking ahead

It is now considered extremely likely that both the direct and indirect impacts of the COVID-19 pandemic will drive up demand for mental health services. Given that SMI services (and mental health services more generally) were struggling with capacity and flow before the pandemic hit, it is important that any additional demand is identified by ICSs and PCNs to model the impact on services locally. With COVID-19 (as with all aspects of SMI care), if trusts are to mitigate increased or changing demand, they must pay close attention to the linkages and dependencies that exist between different levels of service and with other system partners. Capacity is a system-wide issue.

NHS England and NHS Improvement has committed to overseeing a recovery in mental health services in the wake of a focus on emergency service provision. Much non-emergency treatment was disrupted during the first wave of the pandemic and more probably will be as subsequent waves take place. A recovery plan in part will focus on the lessons learned from the efforts to maintain mental health services during the adversity.

A broad array of measures are needed in terms of future-proofing the capacity of mental health services, including:

- adequate capital investment to modernise outdated facilities (such as by eliminating dormitory inpatient accommodation, and ensuring that all inpatient accommodation is single occupancy and en-suite);
- developing robust information systems (including hardware infrastructure, software that is user friendly, and connectivity that is robust and able to function at the necessary speed for demand);
- provision of clinical facilities and hubs that are fit for purpose and located to best meet need.

A key area of focus, as acknowledged by the NHS LTP, is the mental health workforce. Given the known shortages in professionally qualified and non-professionally-qualified staff, trusts must work to fill gaps locally in line with the indicative workforce expansion outlined in the NHS LTP Mental Health Implementation Plan. Services must also be planned in a way that does not demand skill mix models that are unsustainable and likely to perform poorly owing to lack of certain staff. We are aware of innovative approaches in this area, but their use remains patchy and some are still at early stages of testing.

Another area of focus is staff morale and welfare. Steps must be taken to limit tasks that create avoidable frustration – and possible burnout. For example, reducing the time required for clinicians to enter data into trust electronic records and reducing the number of steps and time needed to extract crucial information to support clinical decision-making are obvious areas where rapid progress can be made.

Across all staffing areas, a focus should be placed on reducing vacancy rates and, especially in terms of psychiatrists, relying less heavily on agency and locum staff.

## Recommendations

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **4.** Trusts must ensure that the aims of the NHS LTP Mental Health Implementation Plan and LTP transformation funding are met locally. | **a** All trusts to work with system partners to ensure that the Mental Health Investment Standard is met locally, and that they have nominated finance/transformation leads at senior level with a thorough understanding of the Standard, and can specifically identify the growth in investment expected in each service area between 2018/19-2023/24, and works with ICS/CCGs to ensure the trust receives its share of investment in line with that growth. And to regularly report at board and ICS and STP level on the success of implementing the requirements set out in the NHS LTP Mental Health Implementation Plan. | Trusts with support from GIRFT, ICS/STPs, CCGs, NHS England and Improvement | For progress within 12 months of publication |
| | **b** Trusts to contribute to new NHS England and NHS Improvement national financial planning process to allow triangulation between CCG stated growth in mental health investment and mental health trust income (and, where necessary, reconciliation between the two). | | |
| **5.** Trusts need to work with partners locally and through national bodies to establish and train sufficient numbers of professionally qualified staff – including nursing and medical staff, allied health professionals (AHPs), and clinical psychology, pharmacy and social work staff – to meet the patient need for SMI services in England. Trusts also need to reduce vacancy rates and the reliance on agency and locum staff. | **a** Key national bodies to ensure that there are adequate numbers of undergraduate and postgraduate training opportunities to meet trust-level workforce demand. | Trusts with support from GIRFT, ICS/STPs, NHS England and Improvement, Health Education England, Royal College of Psychiatry | For progress within 12 months of publication |
| | **b** Trusts to identify gaps in being able to recruit and retain staff with the necessary qualifications to fill key roles currently and in relation to future development of services to work with partners, including but not limited to Health Education England, to map demand and capacity for future workforce so that supply meets future need. | | |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **6.** Trusts need to carry out regular ongoing consideration of opportunities to improve skill mix and evaluation of the impact of any changes or innovations. Such opportunities might include increasing the numbers of peer support workers and professionally qualified staff, including nursing, medical, AHP, clinical psychology, pharmacy and social work staff, and increasing the range of posts such as physician or nurse associates, to further develop new roles (both professionally qualified and non-professionally qualified) and models of care delivery. | **a** Trusts to routinely consider skill mix in any workforce reviews or developments, such as the national projects referenced in the NHS LTP Mental Health Implementation Plan, to be based on local needs assessments, including JSNA and the best available evidence. | Trusts with support from GIRFT, ICS/STPs, Royal College of Psychiatry | For progress within 12 months of publication |
| **7.** Trusts need to ensure that existing staff capacity is efficiently utilised and clinician time used to best effect; trusts also need to look at staff wellbeing and support. | **a** Trusts to consider implementation of voice dictation software for data entry.<br>**b** Trusts to improve the IT infrastructure and functionality of systems for timely input and retrieval of information.<br>**c** Trusts to review use of staff time (particularly professionally qualified staff), and clearly outline expectations and deliverables in terms of time management in clinical practice to make best use of professional skills.<br>**d** Trusts to ensure that opportunities are seized from developing the framework for core digital capabilities in mental health services, building on work underway e.g. as described in the Topol Review. | Trusts with support from GIRFT, Health Education England, | For progress within 12 months of publication |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **8.** Trusts need to ensure that their systems are not routinely running at or very near maximum capacity in order to reduce staff burnout and risk of errors, give sufficient flexibility to deal with surges in demand, and allow system thinking and review time. | **a** Trusts to ensure that average inpatient bed occupancy rates are no more than 85% in line with Royal College guidelines. | Trusts with support from GIRFT, ICS/STPs, Commissioners | For progress within 12 months of publication |
| | **b** Trusts to work on optimising patient flow using tools such as the Red2Green approach. | | |
| | **c** Trusts to work with system partners, including commissioners, to be clear how much capacity has been commissioned for each locality, and how much of the expected demand for SMI services can feasibly be met. | | |
| | **d** Trusts to ensure that there is clarity from commissioners for people whose needs do not reach the threshold for the commissioned capacity in the SMI service and for local community and primary care staff, as to what is locally available for them. | | |
| | **e** Ensure that non-human capacity (such as inpatient accommodation, information systems, team bases and clinical facilities) is fit for purpose and adequate capital investment is available to modernise outdated facilities. | | |
| | **f** Trusts with commissioners to report on all NHS funded acute/PICU bed usage for that area, whether it is being provided by trust-based beds, or other providers (in and out of local area), so that total capacity and usage is routinely visible in board reports. | | |

## Flow

Key to ensuring that capacity meets demand is ensuring that flow within and between stages of care is efficient and timely. Improved flow will prevent patients from being moved from team to team unnecessarily, facing multiple rejections or indeed being accepted for no clear reason (which is unlikely to benefit them and may delay access to appropriate care).

The key issue is that patients must be able to step the intensity of their care up or down as and when is necessary; in essence, people should receive the lowest intensity of service that meets their need. When people do need more intense care, they should have timely access to the appropriate interventions.

Providing adequate rationale for stepping up care at each stage of enhanced input is paramount. Any additional intervention should be based on a clear purpose and accompanied by the aim of stepping back the level of intervention when that purpose is achieved. People may need periods of such more intense input on one or more occasions in their lives. Examples include both shorter-term, intensive interventions such as home treatment and inpatient treatment, in addition to longer-term care such as EIP.

When step-up is needed, it should be as timely and as local as feasible. If patients, families, GPs or other stakeholders (such as landlords) think that there will be no timely help in the event of relapse, they will be reluctant for the person's care to be stepped down. Knowing that a rapid step-up in intensity is available when needed will help to combat this understandable reluctance. Enabling rapid access, re-access and step-down when the purpose of admission is achieved also maximises the availability of existing resources, thus cutting wait times for effective interventions. When effective, this is often referred to as 'easy in, easy out'.

In addition to the factors mentioned in the next few pages, improvements to capacity – such as reducing DNA rates and freeing up clinician time spent on non-clinical tasks – can help to improve flow. As with all aspects of care, paying close attention to the linkages and dependencies that exist in the wider system is vital to ensuring that patient flow is optimal within the system (as well as into and out of it).

### Patient assessments

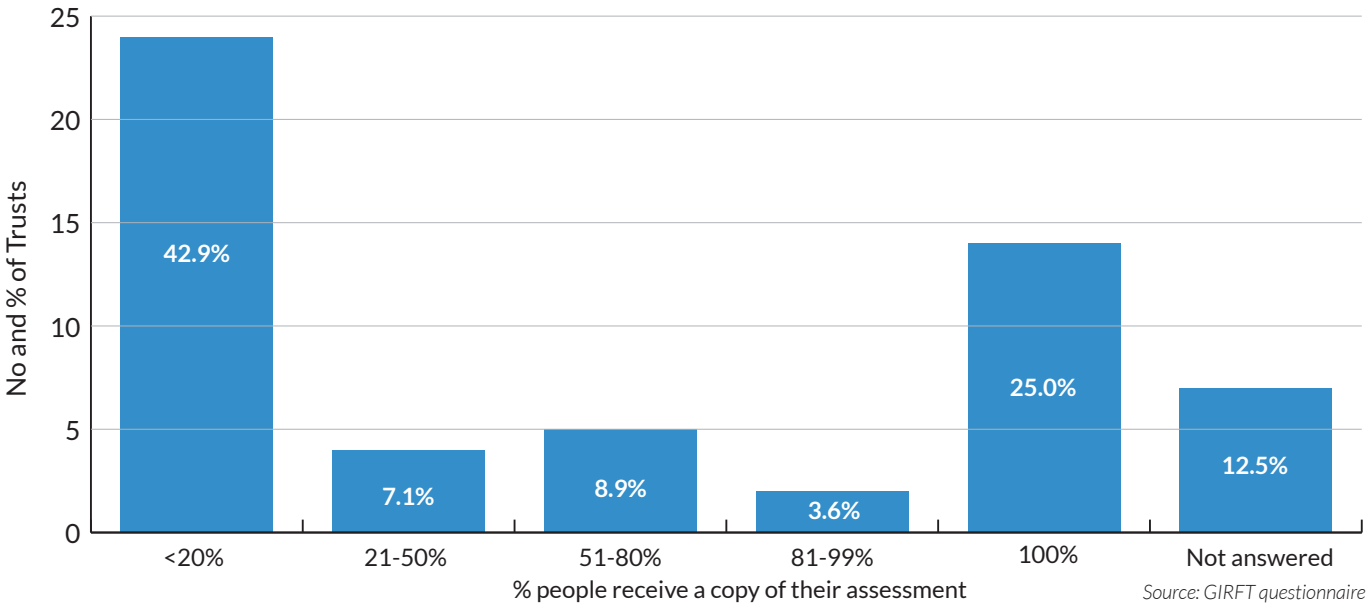
Co-production should be a key part of any treatment journey. Patient assessments provide vital early information with which to plan care. Although assessments should be shared and discussed with the patient in question, there are extremely variable rates of doing so – sometimes, clinicians just share a very brief letter documenting the assessment decisions. This does not offer patients a chance to say whether the assessment is correct, meaning that errors can creep in at the beginning of the care journey. This can skew subsequent decision-making, ultimately wasting time and resources, and at worst leading to tragic outcomes.

The need for patient involvement also applies to subsequent major reassessments, including things labelled as team formulations or similar. Not sharing such information means that the care and treatment cannot truly be described a person centred or co-produced, nor does it fit with the 'nothing about me without me' objective.

Sharing assessments helps to eliminate errors, thus reducing avoidable risks and improving the quality of opinions – and plans based on those opinions. This improves both flow through the system and individual patient outcomes.

There will be certain occasions, in line with current legislation and guidance, when certain information should not be shared, but such situations are rare. When this is the case, it should be noted and captured by the trust so that there is a reporting system to monitor appropriate usage. Ideally, national redesign of mental health services will eventually yield a situation where people have access to their own records routinely as quickly as is feasible. This is often referred to as a 'patient portal'; we were pleased to hear in GIRFT deep-dives that at least some trusts/ICSs are ensuring that mental health is being included in the planning and delivery of such portals.

*Figure 21: GIRFT questionnaire: "What percentage of patients receive a copy of their assessment?"*




*Source: GIRFT questionnaire*

CASE STUDY

## Sharing assessment and care-planning information with patients

### Worcestershire Health and Care NHS Trust Mental Health Liaison Team

When Worcestershire's Mental Health Liaison Team (MHLT) was going through the Psychiatric Liaison Accreditation Networks (PLAN) accreditation process in 2007, the PLAN review highlighted that the team did not routinely provide or offer patients a copy of their assessment.

To solve this issue, the team added a box to the tailored care plan for patients to tick if they want to receive a copy of their assessment. A copy of this care plan is then sent electronically to the services administrative team, which is responsible for ensuring that the completed assessment is sent to all relevant parties, including the patient (if requested).

#### Keeping patients, carers and GPs in the loop

All patients assessed by the MHLT are now offered a full copy of their assessment, to be sent the next working day. They are also provided with a tailored mental health liaison care plan immediately following the assessment, to ensure that they and any carers are not left without vital information. Patients discharged from adult mental health inpatient units are equipped with a discharge care plan which contains a summary of the information sent to their GP.

All urgent patient assessments from within the urgent care pathway (from the Crisis Resolution Team and the MHLT) are sent electronically to the patient's GP (and any other clinically appropriate location) on the next working day to support any onward referral and actions. Assessments are also available via the trust's electronic notes system immediately after completion.

## Core community interventions

In terms of community care for SMIs, the NHS LTP sets a goal of establishing a service based on new and integrated primary and community services. Primarily, the aim of this strategy is to allow patients access to care and support at the earliest point of need, so that they continue to live in their communities.

The reformed community offering will include continuous care across primary and secondary services. One stated aim of the plan, which includes improved access to psychological therapies and physical care, is that patients are helped to 'get better and stay well'. This focus on sustainable, community-based recovery is to be welcomed, and should go some way to improving the cohesiveness of community services.

Access relies upon (but is not guaranteed by) the availability of community mental health services. Access has to be appropriate and equitable to all sections of the local community. It is known that certain factors such as telephone-only access to make or change appointments discriminate against a range of sectors of the population; it is essential to ensure that access systems are responsive and appropriate for all of the local population.

In terms of current care, community-based services were rated as excellent or good by 76% of people in the CQC's 2019 Community Mental Health Survey. However, the CQC survey also reported continued declines in some areas earmarked for improvement since 2014:

- seeing NHS mental health services often enough;
- being given sufficient time to discuss needs and treatment;
- agreeing care to be received and being involved in the process;
- being given help and advice with finding support with physical health needs, financial advice or benefits.

Such declines are disappointing but perhaps not surprising in the light of declining core community capacity and increasing demand over those same years. Encouragingly, the NHS LTP specifically recognises and supports the need for increased capacity and better flow in mental health services as critical to further improving quality for all.

As with elsewhere, issues with data exist within core community services. For example, data is not available on which treatments people receive, so there is a reliance on sources such as EIP survey data and patients' notes to assess use and variation of interventions. Neither of these are viable in the long term as ways of assessing routine interventions and impacts for the population being served. One bright spot in this area is the work done by the NHS South region, which has published detailed data on commissioning and delivery of EIP services in its 2019/20 EIP Programme annual report. Releasing such information into the public domain is a commendable example of open benchmarking.

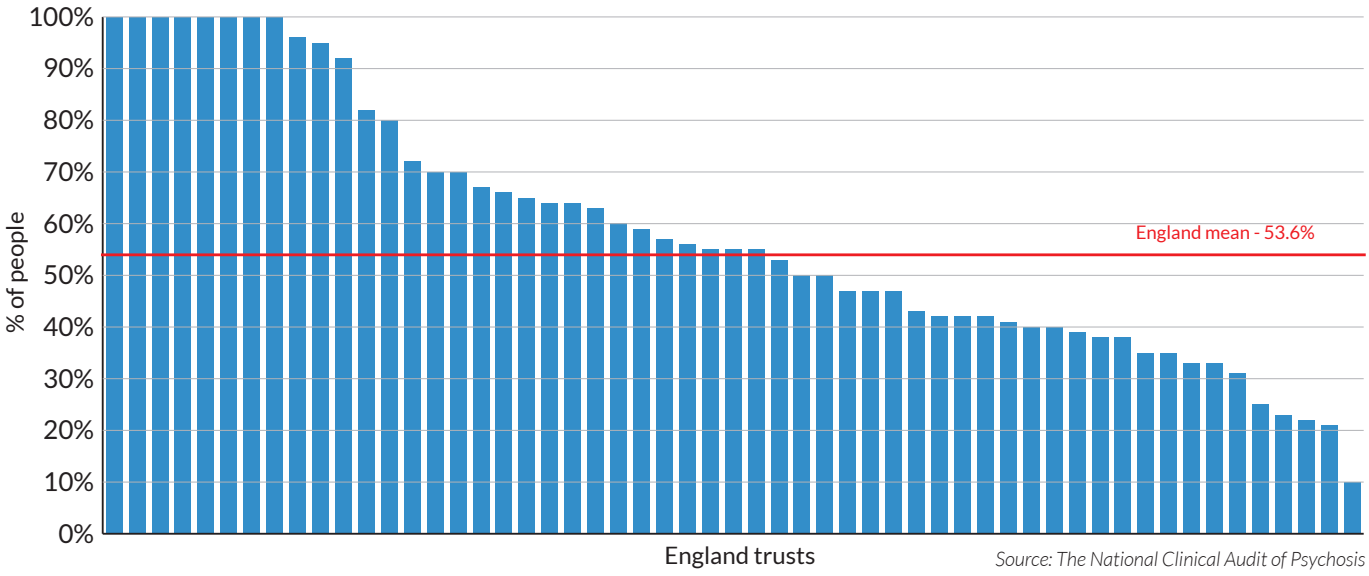
NCAP audit data of EIP metrics show huge variation on uptake of NICE-recommended interventions, a target of improvement in the NHS LTP. For example, whereas several trusts offered clozapine to 100% of patients with first episode psychosis after they had either not responded to or tolerated other antipsychotic drugs (as per NICE guidance), this drops to 10% at the lowest level. Similarly broad variation exists in the use of cognitive behavioural therapy and family intervention.

[62] *Care Quality Commission, 2019. 2019 community mental health survey. www.cqc.org.uk/sites/default/files/20191126_cmh19_statisticalrelease.pdf*

[63] *Time4Recovery, 2020. South of England Early Intervention in Psychosis programme annual report 2019-20. https://time4recovery.com/wp-content/uploads/2020/03/South-EIP-Annual-Report-2019-20-Final.pdf*

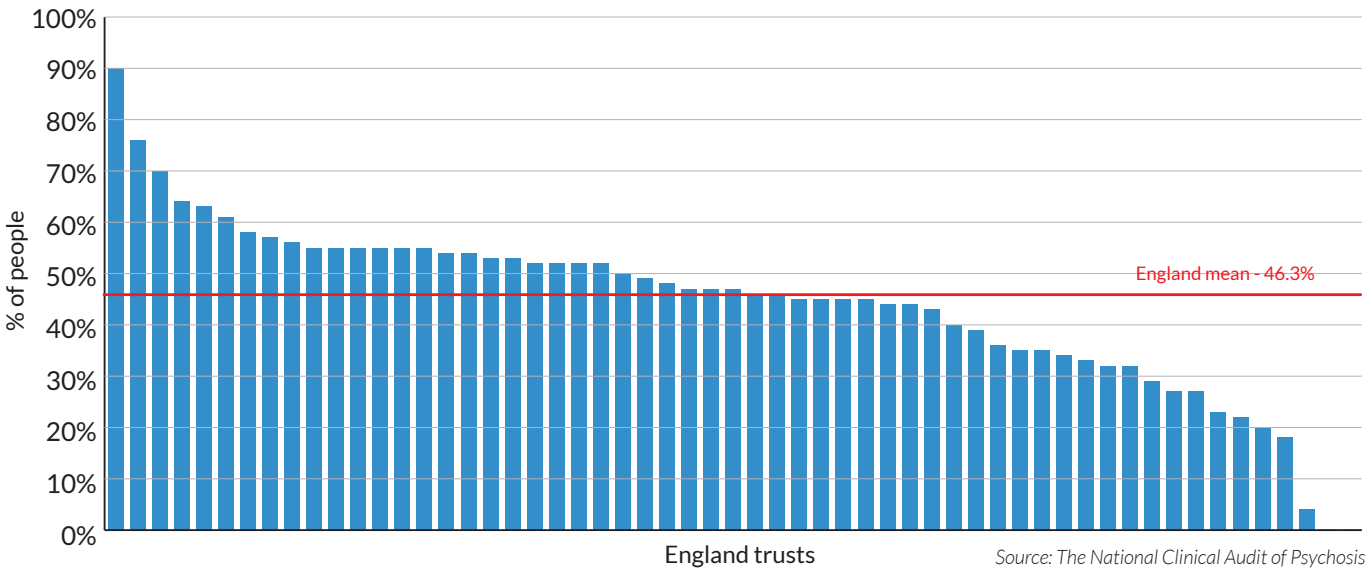
[64] *NICE, 2014. Psychosis and schizophrenia in adults: prevention and management. www.nice.org.uk/Guidance/CG178*

*Figure 22: Percentage of patients with first episode psychosis offered clozapine after not responding adequately to or tolerating treatment with at least two other antipsychotic drugs, 2018/19*



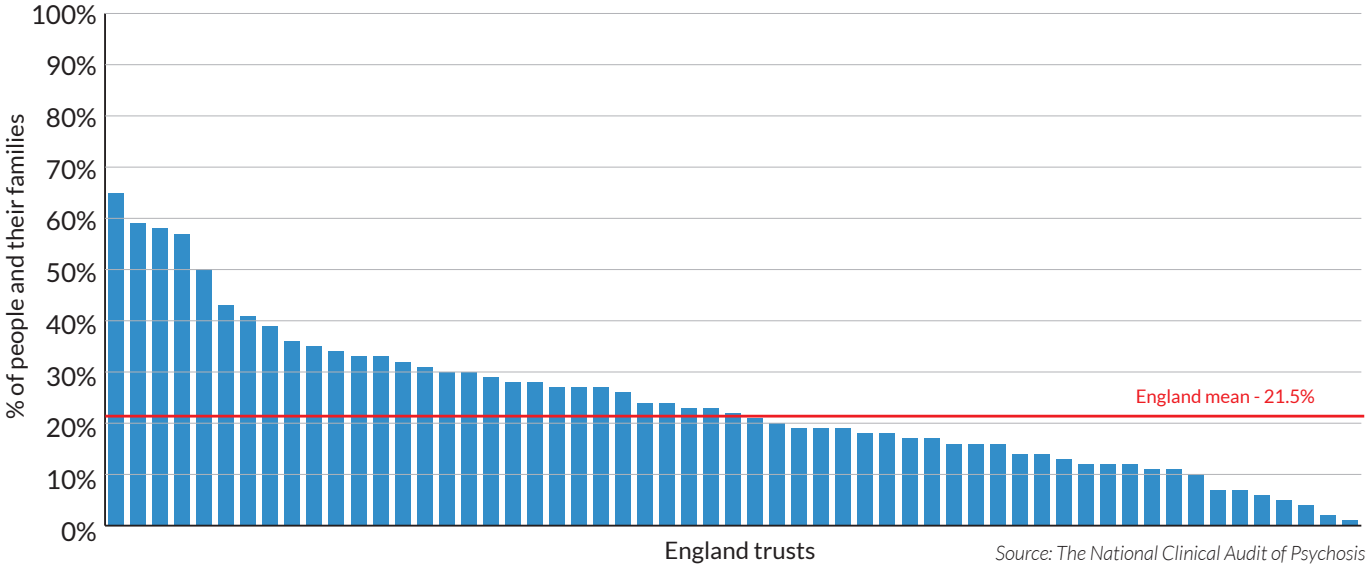

*Source: The National Clinical Audit of Psychosis*

*Figure 23: Percentage of patients with first-episode psychosis who took up cognitive behavioural therapy, 2018/19*




*Source: The National Clinical Audit of Psychosis*

***Figure 24: Percentage of patients with first-episode psychosis who took up family intervention, 2018/19***




*Source: The National Clinical Audit of Psychosis*

People with psychoses make up the majority of hospital admissions, so it is important that their care and treatment is optimised early to reduce primary, secondary and tertiary issues and hence improve lifetime outcomes, including by reducing the likelihood that they will need to spend time in hospital. Using lessons from the variation in EIP provision will facilitate development of opportunities to capture similar metrics for interventions in all core mental health teams.

Recording of interventions is likely to be improved by the introduction of SNOMED CT clinical terminology into MHSDS. If properly supported, use of SNOMED CT will allow thorough, systematic and standardised coding of conditions, treatments and other information vital to delivering best care and treatment within electronic health records.

One principle behind SNOMED CT is that it will facilitate better shareability of and access to key information at key times, both for clinical and service development and review purposes. This should reduce the need for duplication of assessments, tests and use of interventions that have not worked previously, something that contributes to wasted time and resources, and leaves affected patients legitimately feeling that they have not been listened to.

As mentioned above, it is also critical that the first major assessment after first contact with mental health services is thorough, is shared with the person and is easily accessible (both digitally as an ongoing record and on paper at patient request) as the trusted core assessment that can be reviewed and updated over time. This same need for shareability and ease of access extends to other aides to effective co-production working, such as advance directives and health passports.

## Crisis presentations and acute mental health services

The NHS LTP sets an ambition for comprehensive crisis pathways that are able to meet the broad range of needs and preferences for crisis care access, whether in community settings, people's homes, A&E or inpatient services. Part of this will involve a greater role for alternative forms of care (such as crisis cafes and safe havens) for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways.

Crisis contact will made be through the 24/7 NHS mental health crisis single point of access telephone service, which will usually be able to help people access core and other community services in a timely manner, but will also, when higher-intensity acute care is essential, link new and existing patients into acute services (encompassing intensive home treatment, acute adult and older adult inpatient wards, and PICU wards). Although we refer to CRHT services to describe such care, how these functions are delivered will vary appropriately from area to area to take into account local need and geography.

## Crisis access to mental health services

Crisis services should provide equal, open access to people of all ages – there are no stipulations as to what constitutes a crisis, only that the person in question feels that they are experiencing a mental health crisis. Despite the best efforts of these services, a small number of people who do not feel that they are in crisis or that they need inpatient treatment will be detained in crisis under the MHA if the statutory criteria require this.

The vast majority of people contacting urgent services such as the 24-hour crisis line will be able to access appropriate help without requiring acute care. Where acute care is needed, it should be available in a timely manner as close to home as feasible. Most admissions to acute mental health inpatient care are informal – that is, they are not the result of people being detained under the MHA.

Crisis services have developed since they first started, and the longer-established ones are now highly skilled at delivering this first point of contact. Before COVID-19 struck, many mental health services had limited capacity for crisis contact. One quick response of mental health services to COVID-19 was rolling out full 24/7 access by the end of March 2020, a full year ahead of schedule.

For patients already in the Route 1 pathway of services, any necessary step-up in intensity of care (to intensive home treatment or acute inpatient treatment) should not require access via the crisis line. Instead, this should be managed as part of the patient's ongoing treatment plan (although the crisis line does remain an emergency option).

CRHT teams are best placed to decide which cases can be best treated in the community and should therefore act as gatekeepers to inpatient admission and discharge.[65] This is because they know the local system, including what support can be put in place in the local community, and which cases will have a clear purpose of admission necessitating inpatient admission. CRHT teams are also best positioned to determine when the purpose of inpatient admission has been sufficiently addressed to the extent that remaining care and treatment would be better delivered in the community. In 2018/19 inpatient admissions were the sole responsibility of CRHT teams in only 58.2% of trusts, leaving considerable scope for improvement.

Admission to an acute mental health inpatient bed should never be viewed as a last resort. Inpatient admissions should take place at the right time to meet a specific purpose, not delayed until a situation has broken down to a point where avoidable added complications result in much longer inpatient stays. Equally, admissions should not be used as a default option to obscure any lack of adequate community services. Admission, like any intervention, is not neutral – it carries risks of harm as well as potential benefits, so there must be a clear, case-specific purpose that takes into account potential harms and benefits.

The role of CRHT teams also extends to bringing attention to options that make detention under the MHA unnecessary – or, if it is necessary, to ensuring that there is a clear purpose to its use, so that the duration of admission can be as short as possible.

In terms of best practice, CRHT service delivery has historically been tracked using the CORE Fidelity criteria, a scored index of measures and standards.[66] In 2018/19 there was great variability around the country in the coverage of CORE Fidelity standards, and around the age groups covered by them. However, the rapid roll-out of services driven since then by COVID-19 has addressed these issues, partly through urgent redeployment of resources. Although this was a major achievement, redeploying staff was recognised as an urgent, short-term solution. The task in subsequent months has been to solidify this success into a sustainable evolution of services in the long term, including permanent staffing.

Trusts are actively working on this by looking at how to ensure key features:

- Calls to crisis services are answered rapidly, and alternative options such as email and text services are available for those who may struggle with telephone-only access.
- Contact points best link into wider crisis pathways.
- Sufficient (and sufficiently diverse) capacity is available beyond the initial contact point.

[65] *We recognise that there is concern that the term 'gatekeeper' can be seen as synonymous with someone responsible for preventing access to a service. However, we use the term in the sense that CRHT teams oversee movement both in and out of acute inpatient units.*

[66] *Lloyd-Evans, B., Fullarton, K., Lamb, D., et al, 2016. The CORE Service Improvement Programme for mental health crisis resolution teams: study protocol for a cluster-randomised controlled trial. Trials, 17; 158.*

## Purposive admissions

Admissions that lack a clear purpose tend to last longer and create much more uncertainty for patients, families and carers, and inpatient staff teams. A purposive admission sets out the aim of admission (an aim that can only be achieved as a result of admission), and measures the extent to which this aim has been achieved at discharge. If captured and communicated correctly to patients and their families, purpose of admission positively impacts overall experience and can reduce length of stay.

For admission to be truly purposive, trusts must measure success of achieving that purpose at discharge. Unfortunately, although around 89% of trusts capture purpose of admission, only about a third measure success of achieving that purpose at discharge. As such, many trusts are not able to demonstrate their overall success at meeting the needs of patients when they are admitted to acute inpatient care. This is not to say that this is not recorded somewhere in the patient record, rather that it is currently not available in an accessible form for routine reporting and evaluation.

***Table 10: Crisis and emergency care data collection and review***

| | Yes (% and number of trusts) |
|---|---|
| Do you capture purpose of admission to inpatient care? | 89.1% (49/55) |
| Do you measure success of achieving purpose of admission at discharge? | 35.7% (20/56) |
| Do you capture purpose of admission to home treatment? | 88.9% (48/54) |

*Source: GIRFT questionnaire*

Discharge should proceed promptly once the purpose of admission has been met, as long as any further required assessments can be done in the community as part of normal discharge and aftercare, or as part of specific arrangements such as discharge to assess. It is therefore essential to identify (and keep under review, from admission to discharge) which elements of care and treatment can only be undertaken in hospital. The patient in question can then be discharged as soon as the relevant items have been addressed, allowing ongoing care and treatment to proceed in the community.

CASE STUDY

## Reducing relapse and readmission by supporting community living

### South West London and St George's Mental Health NHS Trust Adult Community Occupational Therapy

Graduated Living Skills Outside the Ward (GLOW) is an occupational therapy-led intervention aimed at reducing relapse and readmission on hospital discharge by supporting people to take a more active role in their life and health. It includes strategies to understand an individual's strengths and to develop skills in looking after themselves and taking part in their community, thus reducing relapse and readmission to hospital.

#### A tailored, one-to-one referral service

Via a centralised referral system, GLOW provides evidence-based, manualised occupational therapy of fixed duration – four months – to support evidence-based practice and increased throughput and capacity in occupational therapy services. One-to-one intervention is delivered following discharge from acute inpatient wards.

During an initial eight-month pilot, GLOW:

- decreased the average number of days in hospital from 15 to 7 days;
- decreased the number of contacts with home treatment teams from 14 contacts to 1.

Those receiving support via GLOW continue to demonstrate increased participation in both the quantity and variety of productive activities, including the ability to look after themselves and their home, and the resumption of social relations, work and leisure.

## A&E attendance

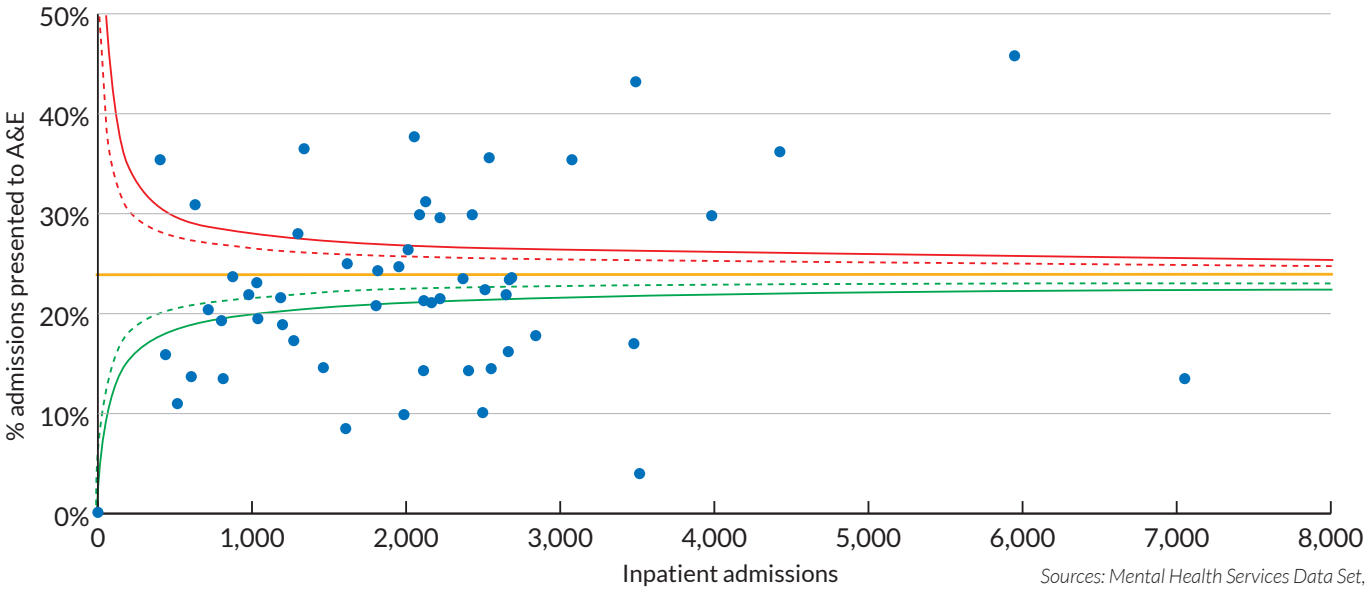
A&E attendance can be unsettling for those experiencing mental health crisis. Many people with mental health problems will require access to A&E, whether primarily owing to physical health issues or a mixture of physical and mental health issues. It is therefore essential that A&E departments are able to equitably treat and meet the needs of those who may present there in a mental health crisis or with significant mental health problems. That is not to say that A&E should be the preferred point of contact for mental health crises. If access via Route 1 and appropriate step-ups in care work effectively, many fewer people will need to attend or be admitted via A&E as the result of a mental health emergency.

MHSDS data for 2018/19 demonstrate significant A&E attendance in the hours before acute mental health inpatient admission (see **Figure 25**), suggesting that there is work to be done before A&E presentations can be limited to essential need.

There is also a lack of systematic analysis and reporting of data with regards to which patients go to A&E or use liaison services when they might be better served if Route 1 worked more effectively in the local area. This lack of data – a system-wide issue partly due to lack of resources (including data collection and retrieval systems) and partly due to data definition and quality issues – also prevents analysis of the numbers of adults who have both mental and physical health needs, and the relative significance of each in any given A&E attendance. The use and collection of data in A&E is not covered by the scope of this report – Emergency Medicine is covered by a separate GIRFT programme.

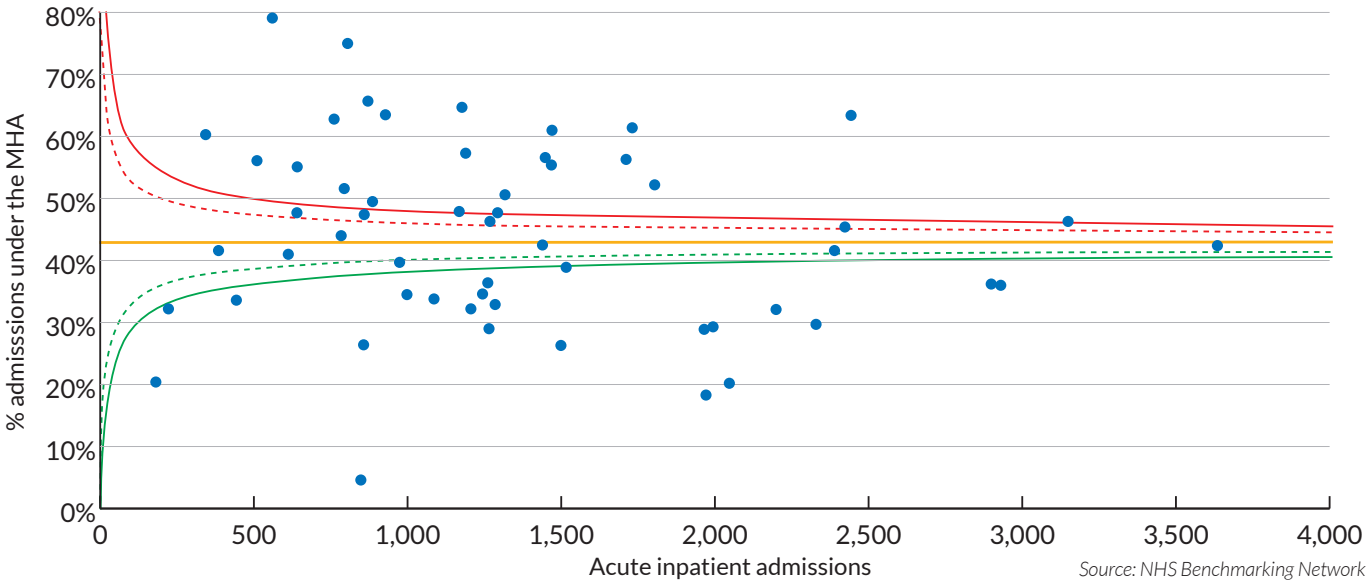
Psychiatric liaison services to acute hospitals do serve a vital function for people with mental health emergencies presenting to A&E. However, they have broader and equally important roles in supporting and treating people in acute hospital services with primary or secondary mental health conditions, as well as in ensuring that people are linked into community mental health services as needed. Most liaison psychiatry services are based within general hospitals. However, liaison psychiatry services may also work with GPs and community health services.

*Figure 25: Percentage of mental health admissions presenting to A&E up to 24 hours prior to admission, 2018/19*




*Sources: Mental Health Services Data Set, NHS Digital Secondary Uses Service*

*Figure 26: Percentage of acute mental health admissions via the Mental Health Act, 2018/19*




*Source: NHS Benchmarking Network*

CASE STUDY

## A co-produced alternative for people accessing A&E or out of hours services

### Northamptonshire Healthcare NHS Foundation Trust Crisis Cafés

Under a redesign of its mental health crisis pathway, Northamptonshire co-produced crisis cafés with MIND. These opened in 2017 as an alternative to emergency departments and out of hours services for people experiencing a mental health crisis.

Six cafés operate in key areas across the county from 5pm to 10pm each night. They help to drive down the need for referral-based services and offer an outlet for users and carers who often feel that they have to tell their story repeatedly to many professionals. Service users are directed into a service that best meets their needs.

#### Easing the load on A&E and out of hours services

The service also provides an accessible option to strategic partners including the police and ambulance services, who are now able to take people in distress directly to a crisis café. This ensures that users reach the correct pathways in a timely fashion and reduces the impact on A&E and out of hours services.

Balancing the savings made on costs on emergency care (encompassing A&E, urgent care and treatment, and police and ambulance services) with the cost of running the cafés, Northamptonshire says that an overall saving of between £1,716 and £13,393 is made each month (equivalent to between £20,592 and £160,716 per year).

The trust has also opened a crisis house offering short-term admissions of between two and five days to people who would otherwise be admitted to mental health inpatient services.

## Detention under the Mental Health Act

As can be seen in **Figure 26**, there is wide variation in the percentage of people admitted under the MHA in different trusts. Although a variety of possible explanations have been put forward for this in the literature and in GIRFT deep-dives, much of this variance is unexplainable with available data. What is clear is the idea that it is only possible to get someone admitted if they are detained under the MHA is a myth.

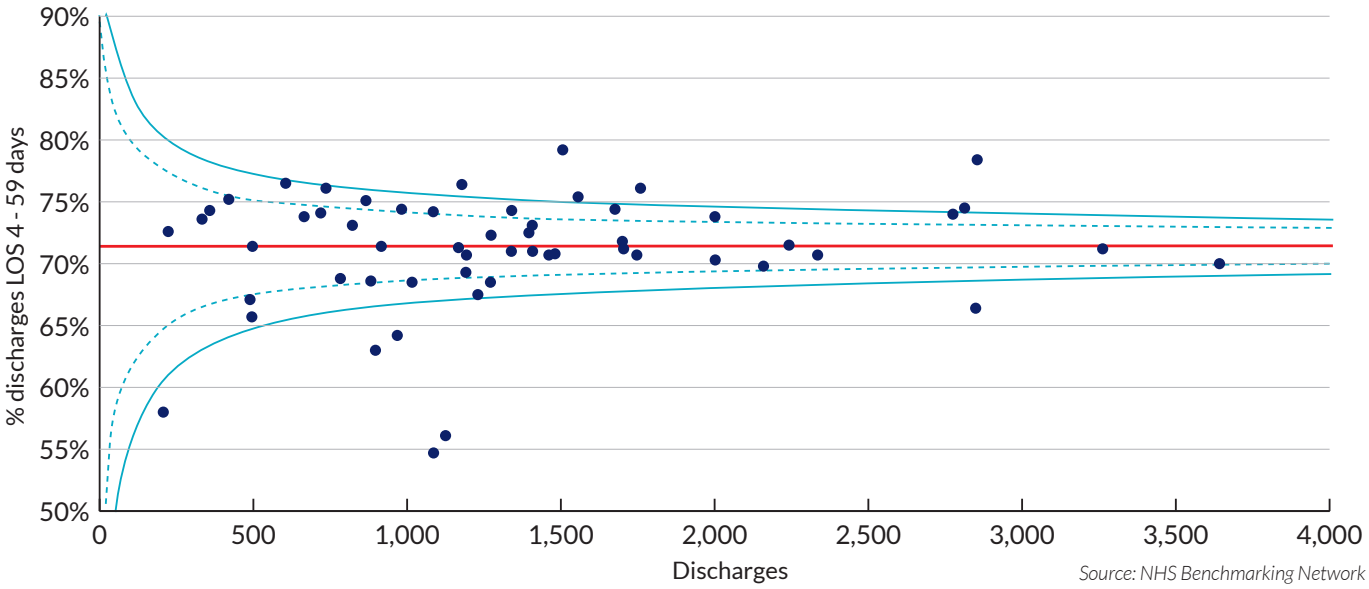
## Optimising inpatient care

In terms of inpatient care, one welcome aim of the NHS LTP is the reduction in length of stay (LoS) for all services to the current national average of 32 days (or below) in adult acute inpatient mental health settings. In 2018/19 acute inpatient LoS was 60 days or above in about 15% of cases, implying at least some inefficiency in flow between different areas of care.

Just as widespread extended length of stay suggests inefficient flow between different areas of care, short stays also need to be monitored, as they may imply unnecessary inpatient admission. About 15% of inpatient admissions in 2018/19 resulted in hospital stays of 0–3 days. Such brief admissions to an inpatient mental health bed are unlikely to produce much, if any, therapeutic benefit, and most such cases could and should receive better care in the community. It is likely that expanding crisis services and alternatives such as crisis cafés, crisis beds and enhanced intensive home treatment options will reduce the numbers of such brief admissions.

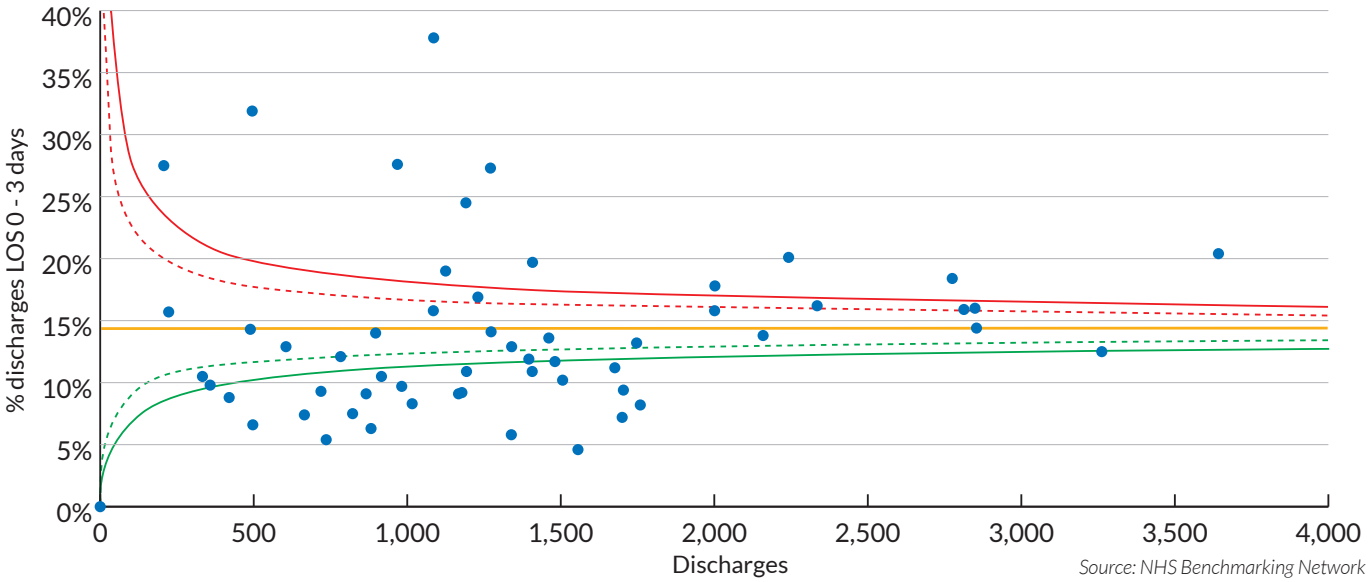
Success in this could lead to an increase in average length of stay (by reducing the amount of shorter stays), again demonstrating that averages on their own are insufficiently informative. We recommend segmentation of lengths of stay and moving towards adoption of a more useful metric. One such possibility is occupied bed days per weighted 100k population, which would allow better capacity planning and flow, thus assisting in delivering the aspirations of the NHS LTP.

*Figure 27: Acute inpatient length of stay 4–59 days, 2018/19*



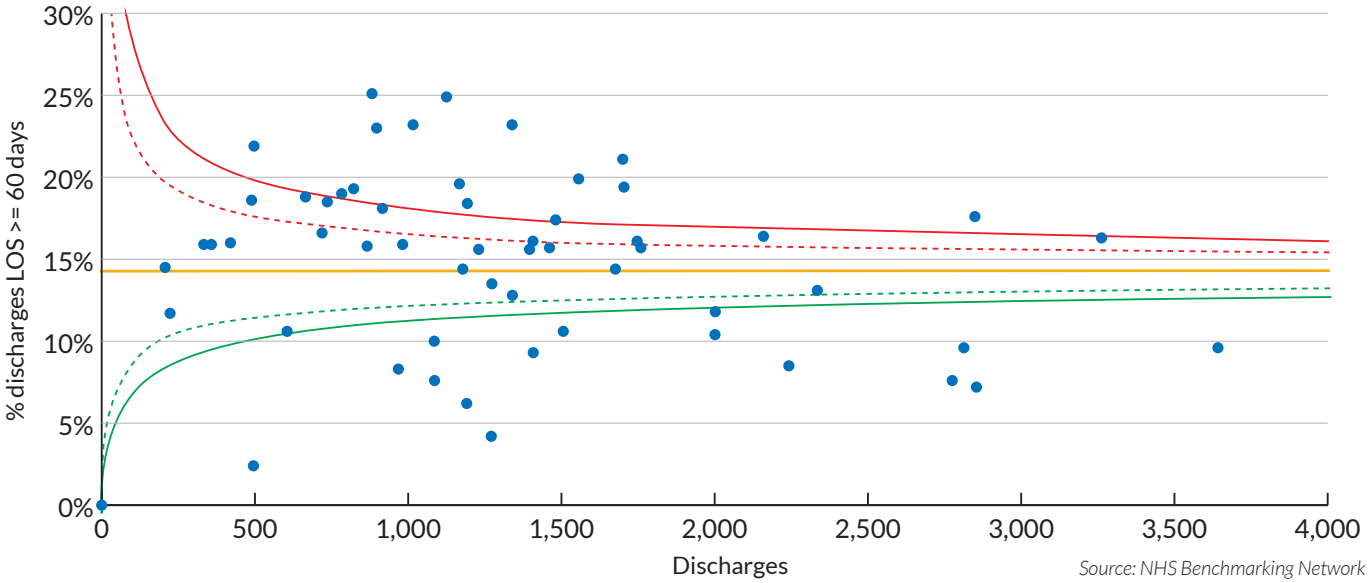

*Source: NHS Benchmarking Network*

*Figure 28a: Acute inpatient length of stay 0–3 days*




*Source: NHS Benchmarking Network*

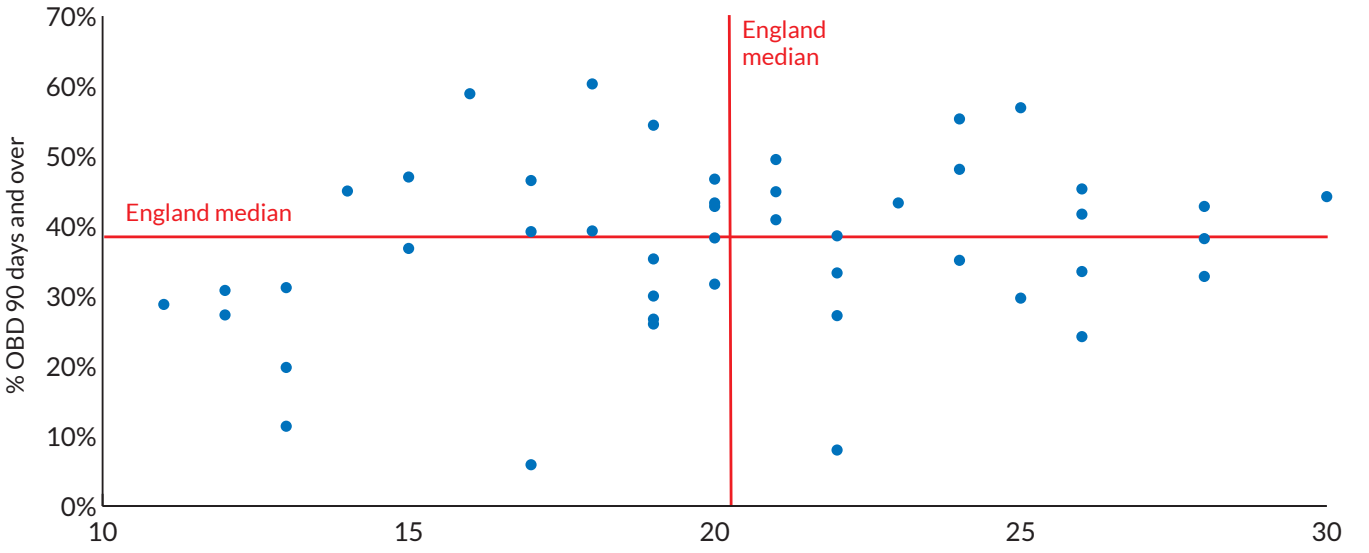
*Figure 28b: Acute inpatient length of stay 60 days and over*




*Source: NHS Benchmarking Network*

Although they are somewhat arbitrary, we have used the designations 'stranded' (length of stay of more than 60 days) and 'super-stranded' (length of stay of more than 90 days) as indicating people who are unlikely to be best served by continuing on an acute inpatient ward. Some patients will spend extended periods in acute care appropriately, because they are showing clear but slower progress (a reminder of the importance of person-centred care). However, for many, such lengths of stay indicate missed opportunities earlier in the care pathway. Some will need input from dedicated rehabilitation services, but many will not. Dedicated psychiatric rehabilitation services will be covered in the GIRFT report on Mental Health Rehabilitation.

***Figure 29: 'Super-stranded' inpatients (length of stay 90+ days) and bed provision, including out of area (OBD = occupied bed days), 2018/19***




*Sources: NHS Benchmarking, NHS Digital*

As well as demonstrating the level and variation of patients who fit into our 'super-stranded' designation, the data on super-stranded patients also illustrates the range of acute beds being used by different trusts. Our data confirms previous findings that there is no correlation between numbers of local acute beds and out-of-area acute bed usage. We were asked whether lower acute bed numbers were explained by greater numbers of rehabilitation beds being used. Our analysis showed this not to be the case; in fact, trusts with more local acute beds also used more rehabilitation beds (within trust and out of trust combined). We were also asked whether greater use of rehabilitation beds (which are generally longer stay) reduced the percentage of patients with longer acute inpatient stays (stranded and super-stranded), but there was no correlation.

All of this strengthens the evidence that effective and robust community mental health services – coupled with timely inpatient admission when essential – is critical to avoiding lengthy inpatient stays and out-of-area bed usage. Nevertheless, it remains critical that, for those who do need inpatient care, such care is optimal and lasts for the shortest length of time needed to meet each individual patient's needs.

CASE STUDY

## Fostering a collaborative, engaged working culture to improve flow and regulate bed occupancy

### East London NHS Foundation Trust

East London NHS Foundation Trust provides mental health services for three inner-London boroughs characterised by high mental health need, deprivation and population growth. However, median inpatient admissions are shorter than the national average (23 days, versus 32), bed availability is good (at 88%) and nearly all rehabilitation is offered in the community. In recent years, out of area bed usage has been zero, and beds have consistently been available to admit people locally whenever clinically indicated to do so.

#### Engaged staff and a focus on clinical leadership

The trust attributes the effectiveness of its services to a range of factors, with high-quality, engaged staff at the core. It recognises the role of maintaining the right culture as a critical factor. There is a strong emphasis on clinical leadership and clinical ownership within services.

There has been a concerted effort to improve the inpatient setting and offer to patients. This has involved concerted, strong leadership in managing flow. Clinical views inform decisions, and there are no separate bed manager roles, as that function is effectively owned by the clinicians and operational managers.

There is a general focus on ensuring that the wider system functions as well as possible, which helps to ensure that care is provided in the community as much as is feasible and appropriate.

One way of optimising inpatient care is by using an improvement tool. One such tool is Red2Green, which is designed to identify wasted time in a patient's journey.[67] By assessing what was not done that could or should have been done to help a patient to reach discharge successfully and quickly, tools like Red2Green help to tackle unwarranted variation and related delays. If implemented correctly (which includes being linked to purpose of admission), use of improvement tools could reduce average length of stay by seven to ten days, with the biggest reductions likely in those with the longest lengths of stay.

Trusts are also increasingly using other proven flow-improvement tools to avoid people becoming stranded. These include:

- active in-reach from home-treatment teams to each ward;
- automatic reviews of cases that have not progressed to discharge by a certain point (30 days, for example), to ensure that opportunities are not being missed.

In all trusts, the vast majority of inpatient admissions involve people known to the trust and who, in many cases, have been accessing trust services for a long time. Trusts are working to identify which people at which stage of relapse are likely to need inpatient admission, so that intensive home treatment can be stepped up earlier or a date for inpatient admission determined in advance, if necessary.

If a person requires admission but is not admitted in a timely fashion to preventative care, community support systems can become exhausted or even completely break down, and may be difficult to restart. As with flow through community teams, if people think that local re-access to inpatient care will not be available in a timely manner, discharge and access to the range of community support available to that person on discharge will be hampered. All of the above initiatives will help to reduce total numbers of occupied bed days and thus contribute to a local bed being available immediately, if it is needed.

With bed occupancy rates tending to exceed the 85% recommended by the Royal College of Psychiatrists, we welcome and commend the types of actions that fit well with both the community transformation and urgent care aspirations of the NHS LTP. We look forward to the advent of increased community options and interventions as NHS LTP funding continues to be rolled out.

[67] *NHS Improvement. Red2Green Campaign. https://improvement.nhs.uk/improvement-offers/red2green-campaign/*

CASE STUDY

## Using Red2Green to optimise inpatient flow amid COVID-19

### Cheshire and Wirral Partnership NHS Foundation Trust

As part of a wider initiative by Cheshire and Wirral to optimise patient flow into and out of acute care, over the past three years the trust has developed Red2Green (R2G) processes and principles (designed to support patient flow by identifying and resolving barriers that prevent patients from progressing along the care pathway). The main motivation of the trust's initiative is that internal or external delays in processes should not leave patients unnecessarily stranded in inpatient care.

#### Making sustainable changes

Amid the COVID-19 pandemic, the trust has developed a new version of its R2G standard operating procedure (SOP) that defines roles more clearly and provides for a better reporting system. This is designed to improve accountability and make it more likely for individuals to undertake actions highlighted in Red2Green board rounds, thus improving each patient's journey through acute care.

Cheshire and Wirral's new SOP has enabled Red2Green to become more embedded in staff thinking as 'business as usual'. The trust says that consistent good bed availability during COVID-19 is one likely impact of the combination of elements that it has employed to optimise its acute care pathway, with no requirement for out of area beds. The trust also notes that CRHT team caseloads have remained steady and manageable during the pandemic, despite staffing pressures.

## The impact of co-occurring conditions

Comorbidities and co-occurring conditions can be a significant factor in the management of mental health problems, and vice versa. Co-occurring conditions can include long-term physical conditions (such as obesity and coronary heart disease), learning disabilities, autism, dementia and substance misuse. In addition, groups such as the homeless, pregnant mothers, veterans and older people can be disproportionately affected by mental health conditions. A general issue is that lack of coding in mental health services makes it very difficult to report or analyse any routine data on quantity and impact of co-occurring conditions and/or social risk factors.

According to the GIRFT survey, in 2019 just over 70% of providers offered a specialist older peoples' mental health liaison service. At the time that the survey was conducted, only 37.5% of providers were members of the Veterans Covenant Healthcare Alliance (VHCA), which aims to improve the healthcare that veterans receive from the NHS. However, the percentage of providers who are members has increased significantly since the survey was conducted; 53 mental health and acute trusts are now accredited as Veterans Aware by VHCA.

***Table 11: Trusts' use of specialist services for older people and veterans***

| | Yes |
|---|---|
| For older adults presenting via your linked acute general hospitals; do you have a specialist older peoples' mental health liaison service? | 71.4% (40/56) |
| Are you members of VCHA (Veterans Covenant Healthcare Alliance)? | 37.5% (21/56) |

*Source: GIRFT questionnaire*

A variety of existing measures and some mandated by the NHS LTP seek to manage the co-occurrence of mental health conditions with other issues. For example, IAPT services have now evolved to deliver integrated care for people at the point of delivery. Integrated community models for patients with SMI also offer a more rounded care offering, and physical health checks will be offered to 390,000 SMI patients per year by 2023/24.

The NHS LTP mandates that mental health providers offer clear alignment with wider workstreams, such as Ageing Well, maternity, primary care transformation, children and young people, personalised care, and learning disabilities and autism services.

CASE STUDY

## Managing older patient inpatient flow

### Central and North West London NHS Foundation Trust

The trust's Older People's Mental Health Inpatient Service identified that an injection of focused resources could unblock hotspots in patient journeys to help patients move through the stages of their care more quickly and avoid unnecessary delays and costs arising from waiting times.

#### Providing staff with a dedicated resource

Initially launched as a three-month project, two new dedicated posts – a senior clinical nurse and a social worker – were created to provide a 'Pathway Support' function to problem-solve individual difficulties and avoid unexpected problems that could lengthen the stay of older patients within inpatient mental health care.

The trust found that having dedicated staff to support early, proactive engagement resulted in a more holistic understanding of patient needs, more comprehensive forward planning to account for those needs and a reduction in unnecessary delays to discharge.

The benefits of the approach included:

- significant reductions in unnecessarily delayed stays within inpatient care;
- reduced average length of stay in inpatient care;
- reduced bed occupancy (average bed occupancy fell from 121% to 57%).

The system also yielded significant financial savings – with reduced bed occupancy and staffing requirements, and a consequent reduction in bank and agency nurse usage – far outweighing the cost of the two new posts.

The success of the initial phase resulted in the project being extended to six months, then a year; ultimately, the trust funded the two posts permanently.

## Physical comorbidities

Adults with severe mental illness are more likely to be affected by physical health conditions including obesity, asthma, diabetes, COPD, coronary heart disease, stroke and heart failure.[68] Around 40% of people with depression and anxiety disorders also have a long-term physical condition, while around 30% of people with a long-term condition and 70% with medically unexplained symptoms also have mental health comorbidities.

In addition, suicide occurs more frequently in patients experiencing co-occurring psychiatric and physical illness; the National Confidential Inquiry into Suicide and Safety in Mental Health suggests that safer prescribing should be a focus in primary and secondary care, with particular attention to opioids prescribed to people with long-term physical illness.[69,70] Premature mortality (death before the age of 75) among people with a severe mental illness is 3.7 times the national average, and the gap is growing even as premature mortality in the wider population is falling.[71]

[68] *Public Health England, 2018. Health matters: reducing health inequalities in mental illness. www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness*

[69] *Royal College of Psychiatrists, 20202. Self-harm and suicide in adults: Final report of the Patient Safety Group. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/cr229_self-harm-and-suicide.pdf*

[70] *The National Confidential Inquiry into Suicide and Safety in Mental Health, 2019. Annual Report: England, Northern Ireland, Scotland and Wales. University of Manchester. http://documents.manchester.ac.uk/display.aspx?DocID=46558*

[71] *NHS Digital, 2020. NHS Outcomes Framework Indicators: excess under 75 mortality in adults with serious mental illness. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework*

Much of the rising need stems from older people with physical health problems, which can culminate in a state of general frailty. This can result in a higher level of clinical complexity, most usually with comorbid mental and physical health problems. Effective integrated care and treatment can help prevent or ameliorate much of this additional distress and disability.

In the past, there has been a tendency to treat mental health problems as a barrier to the prevention and treatment of physical health conditions. Mental health problems should instead be seen as existing alongside any physical comorbidities, with care planned to tackle this holistically. Similarly, recording and reporting co-occurring physical disorders will help in planning flow and services, as the impact of those conditions can and often will necessitate adjustments to mental health interventions. Cross-system sharing of information will facilitate this, as well as reducing the need for duplication of investigations and reducing multiple re-entry of the same information into multiple systems.

The NICE clinical guideline on psychosis and schizophrenia in adults recommends that primary care providers use Quality Outcomes Framework registers to monitor the physical health of patients with SMI.[72] The guideline also advises that patients with SMI have at least one physical health review annually, including checks on weight or BMI, metabolic status, pulse, and blood pressure monitoring.

## Learning disabilities and autism

Both working-age and older adults can have learning disabilities and/or be autistic, and the interaction of both with mental health issues needs taking into account when delivering treatment and designing services. Those who are in these groups can face suboptimal access to the most suitable and timely mental health services, leading to an increased risk that they will present via crisis and acute services. As noted, all such late-stage presentations of mental disorders tend to be more complicated and categorised by a higher risk of acute inpatient admission.

A 2020 report by the Royal College of Psychiatrists recommends that psychiatrists not only further familiarise themselves with autism and the treatment of psychiatric disorders in autistic people, but also maintain a close relationship with local autism services.[73] This includes making community mental health services more accessible and responsive to autistic people requiring care for mental health conditions, thus allowing earlier treatment and reducing the risk of crisis presentations.

A 2012 report found that services were failing to meet their legal obligation to enable autistic people and/or people with learning disabilities to have equitable access and effective treatment.[74] The GIRFT survey found that only a minority of trusts collect and review access and outcomes data for people with learning disabilities and autistic people in mental health services.

***Table 12: Trusts' data practices for people with autism and learning disabilities***

| | Yes |
|---|---|
| Do you collect and review data on access and outcomes for people with autism presenting to your crisis/acute pathway? | 28.8% (15/52) |
| Do you collect and review data on access and outcomes for people with learning disability presenting to your crisis/acute pathway? | 39.6% (21/53) |

*Source: GIRFT questionnaire*

[72] *NICE, 2014. Psychosis and schizophrenia in adults: prevention and management. www.nice.org.uk/Guidance/CG178*

[73] *Royal College of Psychiatrists, 2020. The psychiatric management of autism in adults. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr228.pdf?sfvrsn=c64e10e3_2*

[74] *National Development Team for Inclusion, 2017. Green Light Toolkit. www.ndti.org.uk/uploads/files/Green_Light_Toolkit_2017.pdf*

The use of two tools, Care and Treatment Reviews (CTRs) and the Green Light Toolkit – a self-audit toolkit to improve mental health services – is nationally mandated to improve access to mental health services for those also affected by mild learning disabilities and/or who are autistic.

Use of both helps to reduce the risk of such patients presenting at late stage in crisis, while effective use of CTRs can help to avoid the need for admission or shorten admission duration if a person does need admitting. Their use can also:

- make the likelihood of patients becoming stranded less likely;
- reduce the likelihood of restrictive practices being employed;
- contribute to optimised access for people with mild learning disabilities or who are autistic who should be treated by generic mental health services (70–85% of autistic people do not have a learning disability, and so should not be using learning disability services);
- help to reduce future relapses of mental health conditions and hence reduce risk of further admissions.

Although use of both CTRs and the Green Light Toolkit is nationally mandated, some trusts we surveyed were unclear about their usage. GIRFT survey responses revealed that only around half of respondents use the Green Light Toolkit to cover acute/crisis care involving patients with learning disabilities or who are autistic. In addition, a 2017 review by the Public Accounts Committee highlighted a lack of involvement by senior or experienced clinicians.[75]

***Table 13: Trusts' use of CTRs and the Green Light Toolkit***

| | Yes |
|---|---|
| Does your Green Light Toolkit within the trust cover crisis/acute mental health work, including the use of Care and Treatment Reviews (CTRs) for autistic people? | 49.1% (27/55) |
| Does your Green Light Toolkit within the trust cover crisis/acute mental health work, including the use of Care and Treatment Reviews (CTRs) for patients with learning disability? | 55.6% (30/54) |

*Source: GIRFT questionnaire*

In terms of ensuring that adequate skills, knowledge and behaviours are employed by staff when treating patients who are also autistic or affected by learning disabilities, Skills for Health provides two Core Capabilities Frameworks – one for learning disabilities and one for autism – in addition to an Advanced Clinical Practice Capabilities Framework designed specifically for use by AHPs and nursing staff.[76] In addition, the NHS England and NHS Improvement learning disability improvement standards for NHS trusts set out four standards of care to measure quality of service and ensure consistency across the NHS in how people who have learning disabilities and/or are autistic are treated.[77]

[75] *Public Accounts Select Committee, 2017. Local support for people with a learning disability. https://publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/1038/103805.htm*

[76] *Skills for Health, 2019. Capabilities frameworks: supporting autistic people and/or people with a learning disability. www.skillsforhealth.org.uk/services/item/945-capabilities-frameworks*

[77] *NHS England and NHS Improvement, 2018. The learning disability improvement standards for NHS trusts. www.england.nhs.uk/wp-content/uploads/2020/08/v1.17_Improvement_Standards_added_note.pdf*

## Substance misuse and mental health issues

Uncertainty surrounds the prevalence of dual diagnosis of mental health issues and substance misuse. Studies have estimated prevalence rates of 20–37% in secondary mental health services and 6–15% in substance misuse settings; however, methodological and reporting challenges mean that it is unclear how many people are affected by dual diagnosis.[78]

The Co-occurring Substance Misuse and Mental Health Issues Profiling Tool has been developed to support an intelligence-driven approach to understanding and meeting need.[79] The tool collates and analyses a wide range of publicly available data around tobacco smoking, alcohol use and drug use, including data on prevalence, risk factors, treatment demand and treatment response.

Although substance misuse is a major reason why some people end up in crisis, service provision is extremely variable. Many substance misuse services are not NHS-run, which can (but, if well commissioned, should not) lead to issues regarding close co-operation, information sharing and access. We found that the perception of good working links with substance misuse services by mental health trusts varies across the country – and within trusts – depending on local commissioning and delivery arrangements.

In terms of mental health services, people who misuse addictive substances are often perceived as inappropriately excluded from mental health care. At the same time, many people who do use one or more addictive substances are receiving care and treatment for mental health disorders from core community, crisis and acute elements of mental health services. The absence of robust routine data and coding makes it very difficult to form any clear view on the scope of this or its variance across the country.

Use of addictive substances correlates disproportionately with suicide: history of alcohol or drug use has been recorded in 54% of suicides by people experiencing mental health problems; the NCISH suggests a range of clinical measures that could help to reduce suicide risk in such cases.[80,81]

CASE STUDY

### Collaborating with substance misuse services to improve treatment of shared client groups

#### Herefordshire and Worcestershire Health and Care NHS Trust

Although sitting outside of the NHS, addiction services play an integral part in the lives of a percentage of people receiving care via Herefordshire and Worcestershire's mental health services; members of that same client group often present in crisis. The trust identified the need to ensure collaborative working with Cranstoun Worcestershire, which operates the local alcohol and drug recovery services, and remove any barriers to the effectiveness of crisis services.

#### Multidisciplinary approaches and data sharing

An identified cohort of people were presenting with challenges that involved potential mental health issues alongside substance misuse. At times, there were difficulties in communicating across services, and some tensions arose around the understanding of roles and responsibilities. At times, this hindered the effective treatment of and care planning for people in need.

Because of the identified issues, there was a clear appetite across many disciplines to be part of the wider group, as it was recognised that the challenges of this client group touched many services. This gave the trust the opportunity to implement a multidisciplinary approach characterised by regular interface meetings, complex case discussions and a data-sharing agreement.

One of the early outcomes from these interface meetings was a desire to hold informal case reviews to discuss some of the more challenging clients. Along with mutual teaching and learning offers, the benefits have been recognised by all.

[78] *NICE, 2015. Severe mental illness and substance misuse (dual diagnosis): community health and social care services: evidence review. www.nice.org.uk/guidance/ng58/documents/evidence-review*

[79] *Public Health England, 2020. Co-occurring substance misuse and mental health issues. https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth*

[80] *Public Health England, 2017. Better care for people with co-occurring mental health, and alcohol and drug use conditions. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf*

[81] *The National Confidential Inquiry into Suicide and Safety in Mental Health, 2019. Annual Report: England, Northern Ireland, Scotland and Wales. University of Manchester. http://documents.manchester.ac.uk/display.aspx?DocID=46558*

## Substance misuse among older people

The Royal College of Psychiatrists recommends that a greater value be placed on the requirements of older substance misusers.[82] Older people affected by substance misuse are more likely to be affected by comorbid mental and physical health problems, polypharmacy and psychosocial adversity.

The proportion of older people affected by substance misuse continues to rise more rapidly than can be explained by the rise in the proportion of older people in the UK.[83] Substance misuse in older people is also associated with reduced life expectancy.[84] By monitoring levels of substance misuse (including unsafe use of alcohol) among older people presenting to services – as well as through local JSNA data – mental health providers will be better placed to manage the needs of such patients in future.

A range of programmes have proposed ways of detecting and managing comorbid mental health problems and substance misuse. For example, the Preventing Ill Health by Risky Behaviours (2017–19) commissioning for quality and innovation (CQUIN) scheme aimed to embed screening for alcohol and tobacco use, as well as providing brief advice as part of routine inpatient care.[85]

The Royal College of Psychiatrists and Royal College of General Practitioners (RCGP) advocate for doctors to acquire qualifications and competencies through a formal programme, potentially as RCGP 'approved specialists' in substance misuse. Both also advocate for such a qualification being made available to a wide range of clinicians, from generalists to specialists.

## Changes in service provision during COVID-19

Regular patient reviews are needed to ensure that optimal care is being provided during COVID-19. This is particularly important for people with SMI, who may be more marginalised during the pandemic. For example, while video or telephone consultations may be suitable or even preferable for some, they cannot replace direct face-to-face support for others, so they should be offered based on patient choice.

Video contacts have major advantages over telephone contacts in terms of the information that can be shared and in terms of observation. In mental health services for adults and older people, video contact has been relatively underused compared with telephone, and compared with its use in other services. Feedback suggests that this is due to the process being difficult and time consuming (due to unwarranted delays) at the trust's end, rather than for the person being assessed or reviewed. This will need further exploration as part of the modernisation of mental health services. There is increasing (although limited) evidence that reductions in community support and services linked to the COVID-19 pandemic are leading, at least in some parts of the country, to increases in the numbers of people presenting in more severe states and with a greater likelihood to need admission.

One major issue is the (often realistic) fear held by patients that if they are discharged it will take months and much difficulty to receive the appropriate care at a later date. This reluctance to be discharged in turn means that caseloads are too full, meaning that many people are rejected or experience long waits due to lack of capacity.

Trusts have had to start looking at different cohorts of people on caseloads and introducing prioritisation and stratification. This type of segmentation of data can yield important information regarding needs, so as to help make the best use of reduced capacity. There are examples of systems that do an effective job of improving throughput by offering people fast-track access back into services – making use of these offers a real opportunity to get best practice implemented at speed, for COVID-19 and beyond.

[82] *Royal College of Psychiatrists, 2018. Our Invisible Addicts, 2nd edition. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr211.pdf?sfvrsn=820fe4bc_2*

[83] *Ibid.*

[84] *Ibid.*

[85] *Public Health England, 2019. Screening and brief advice for alcohol and tobacco use in inpatient settings. www.gov.uk/government/publications/preventing-ill-health-commissioning-for-quality-and-innovation/guidance-and-information-on-the-preventing-ill-health-cquin-and-wider-cquin-scheme#why-you-should-screen-and-give-brief-advice-for-alcohol-and-tobacco-use*

CASE STUDY

## Discharge to Assess for mental health

**Sussex Partnership NHS Foundation Trust**

Since early 2020, Sussex has been running two Discharge to Assess pilot schemes, one for West Sussex, and one for Brighton and Hove. The pilots have multiple aims:

- to minimise the length of time that patients stay in hospital after they become fit for discharge;
- to provide transitional support for the practical and emotional challenges of transitioning back into the community;
- to provide a community setting from which to undertake further assessments and support;
- to improve patient flow by increasing the range of discharge options available locally;
- to co-ordinate discharge planning between those involved (including patients, families and carers, and the health, housing and adult social care services).

The two schemes have now been extended well beyond their original end date, to March 2021. Patients have been able to access the right support at the right time to smooth their transition from inpatient care back into the community, and fewer patients have stayed in hospital longer than required. In addition, providing short-term transitional community support at the point of discharge has resulted in fewer people needing to access longer-term care services. Patient satisfaction levels within the service are high.

Sussex also reports that between February and September (West Sussex) and April and July (Brighton and Hove) 2,036 bed days were saved, and its business case anticipates an investment return of two to one.

## Looking ahead

Delays increase the risk of mental health problems becoming more chronic and leading to secondary or tertiary problems. All mental illnesses disrupt functioning, and the longer that such disruption continues increases distress for the person and makes restoring functioning more difficult. The initial assessment is therefore very important, but so is timely access to the right inputs and skills.

A common piece of feedback from people accessing mental health services is that they do not feel they have been listened to and/or heard. To truly endorse the 'nothing about me without me' philosophy and provide person-centred care and co-production of care plans, an essential step is sharing assessments with individuals, so that they can correct, clarify and indicate whether they agree or disagree with certain parts. This will mean that the initial assessment is more robust and likely to require fewer full reassessments in future. It will also improve access and flow through the system by reducing multiple duplicate assessments, therefore freeing up clinician time to offer effective interventions to more people.

If patients, their families and carers, and providers are not clear as to the purpose for which someone has been referred for a step-up in treatment intensity, there is less likelihood of addressing that purpose in a timely and effective manner. This inevitably causes delays and slows flow through the system. Capturing purpose of referral and reviewing success at achieving that purpose is essential to making the best use of capacity and skill mix, thus improving flow and ensuring that step-up in intensity is available when needed.

A point that we have made again and again in this report is that paying close attention to system-wide linkages and dependencies is essential to eliminating unwarranted variation in crisis and acute services. To maximise the benefits of available capacity, it is essential that pathways are clear. Ways to ensure this include clear reasons for referral (to reduce instances of people being referred and not accepted), clear systems for reducing DNA and no-contact rates, and clear systems to allow people to move back to lower intensity care when higher intensity care is no longer required. People also need confidence that input can be stepped up to higher-level care immediately when needed.

Co-occurring conditions may increase vulnerability to or the impact of mental illness, as well as altering responses to standard interventions. They therefore need logging and taking into account, or else treatment will not be optimised for that person. This is an area where the NHS LTP commitment to 'new and integrated models of primary and community mental health care [which] will support adults and older adults with severe mental illnesses' is so important.

## Recommendations

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **9.** Trusts need to use routinely collected data to explore unexplained variation in reception and acceptance of referrals. | **a** Trusts to establish and maintain robust systems for measuring demand (referrals received) and supply (referrals accepted into treatment).<br>**b** Trusts to include timely analysis (as part of the board quality dashboard) of where variance occurs – i.e. more referrals received than accepted or first point of contact is not through Route 1 – alongside an explanation and any necessary contingent actions.<br>**c** Trusts to segment data on referrals (received and accepted) to identify if any groups in the local community are under or over-represented at any entry point, and to report on this to trust board and system partners.<br>**d** Trust to flag any identified issues in ICS/STP and PCN discussions. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |
| **10.** Trusts need to engage with patients and carers to identify and reduce avoidable barriers to patient access to SMI services, as well as ensuring that they have fast-track access to CMHTs and other recognised best practices for referral and patient pathway routes. | Examples include:<br>**a** Trusts to provide access options such as email, text and video consultations, and other digital solutions for service users for whom telephone access is a barrier.<br>**b** Trusts to provide clear information on referral and access routes on the trust public website for each service.<br>**c** Trusts to work with local communities to ensure that potential barriers to access for any part of the community are identified and addressed to reduce inequity of service.<br>**d** Ensure that the national standards on accessible information are met. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |
| **11.** Trusts need to monitor, analyse and report on step-up in intensity of services to ensure that step-up is essential, timely and equitable. | **a** Trusts to use established techniques such as (but not limited to) the following:<br>• Capture the purpose of step-up<br>• Step-up when essential, not as a last resort<br>• Use of Red2Green or similar flow improvement methodology<br>• Patient-initiated follow-up.<br>**b** Trusts to establish clear systems for timely step down when purpose of step-up has been achieved.<br>**c** Trusts to capture and use information on system step-up issues such as high rates of section 136, high rates of section 2, high rates of first contact with SMI services or inpatient admission via A&E in discussions with ICS/PCNs to reduce high rates.<br>**d** Trusts to use robust sustainable models for 24/7 access.<br>**e** Trusts to regularly review factors that could potentially impact flow to ensure that people do not become stranded in community teams or inpatient services.<br>**f** Trusts to ensure that trusts services are routinely using evidence-based ways of reducing DNA and no-contact rates. | Trusts with support from GIRFT, ICS/STPs | For progress within 12 months of publication |

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **12.** Trusts need to ensure that person-centred care and co-production of care plans is standard (including to the maximum extent feasible within the law for those detained under the MHA).<br>For people who lack capacity, care planning should follow the principles and rules set out in the Mental Capacity Act. | **a** Trusts to ensure the electronic health record clearly highlights any documents provided by the person to support reviews and/or contacts (e.g. advance directives, hospital passports).<br>**b** Trusts to ensure all assessments and formulations are routinely shared with the person in a timely manner to allow for clarification or correction of any factual errors.<br>**c** Trusts to select the contact method – face-to-face, video link, telephone, text or email – most suitable for delivering the most appropriate intervention, taking into account each person's needs and wishes.<br>**d** Trusts to reduce duplicate assessments by recording once and using often by having timely access when needed to information entered by any team.<br>**e** Trusts to ensure that all of the above are part of the board quality review.<br>**f** Trusts to develop crisis plans as part of care plans in line with NICE guidance. | Trusts with support from GIRFT | For progress within 12 months of publication |
| **13.** Trusts need to record robust, publicly available outcome and intervention data, and share this with partners and people accessing services as appropriate – in the process meeting (but not being limited to) regulatory requirements. | **a** Trusts to commit to recording and reporting outcomes consistently for all patients including – as a minimum at least one clinician rated outcome measure such as paired HoNOS scores.<br>**b** Trusts to routinely record and share patient outcome measures such as DIALOG with a view to linking this into work already underway in relation to the LTP Mental Health Implementation Plan.<br>**c** Trusts to link outcomes with interventions delivered – this requires robust recording and reporting systems that do not reduce clinical capacity by taking significant clinical time to input – using the move to SNOMED CT to help drive this.<br>**d** MHSDS and Model Hospital to be the repository for key data to reduce numbers of ad hoc information requests, and ensure ability for robust benchmarking to help drive quality improvement at all levels. | Trusts with support from GIRFT, NHS Digital, NHS England and NHS Improvement, Care Quality Commission | For progress within 12 months of publication |

## Outcomes

Assessing the effectiveness of NHS mental health services is hampered by broad issues with the recording, analysis and reporting of outcomes data. Often, insufficient patient data is collected to enable analysis of clinical outcomes, while the impact of patients' feedback and involvement in their care is also reduced by problems around data collection and sharing.

In addition, while there is much-reported data on certain negative metrics such as restrictive practices, measures of positive practice and outcomes are sorely lacking. This prevents providers from making a balanced assessment of clinical outcomes and broader effectiveness of care. While services can make some improvements by looking at what 'bad' looks like, they cannot truly improve without looking at what 'good' looks like and seeking to match or better that.

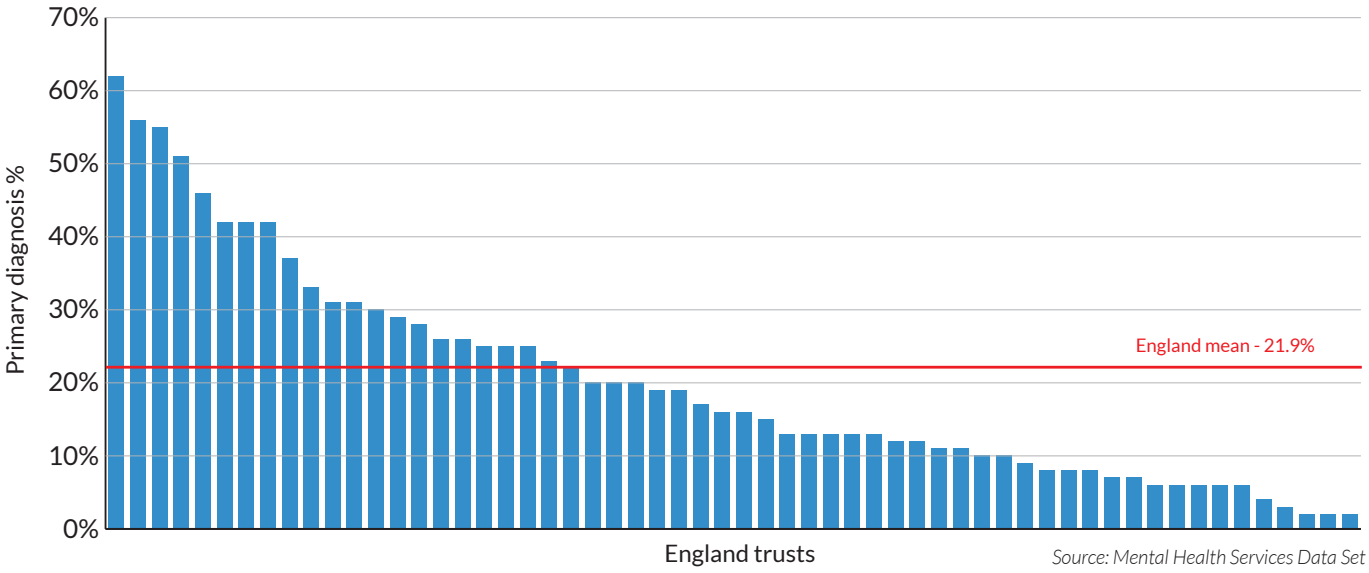
We do note that increasing numbers of mental health trust boards are publishing quality and performance dashboards in their public board papers. We also note the relatively recent but impressive growth in the use of more appropriate ways of displaying such data – using run charts and statistical process control, for example. These all represent positive steps, which, when taken up by all mental health trusts, will facilitate better understanding of service interventions and outcomes. It should go without saying that these issues are not restricted to SMI services, and nor are the solutions.

### Measuring and reporting outcomes

There is a need to measure outcomes consistently and to analyse, report and share them publicly to enable trusts to reduce unwarranted variation. There are a lack of outcome measures in some areas of mental health, and there are major reporting gaps in areas such as diagnostic coding, primary diagnosis and intervention.

The primary diagnosis is often recorded as 'not known', so it is not possible to identify the main condition treated or investigated during that episode. According to MHSDS data, the mean level of primary diagnosis recording in 2018/19 was 21.9%, but this varied on a trust-by-trust basis from above 60% to close to zero.

***Figure 30: Number of cases aged 18 and over with a primary ICD10 diagnosis recorded, 2018/19***




*Source: Mental Health Services Data Set*

Clinician and person-reported outcomes not only help to improve services; they also provide evidence of benefits that can be used when allocating funding for services. Ensuring that outcome reporting is comprehensive and widely utilised will be valuable in painting a detailed picture of NHS mental health services.

The use of the Health of the Nation Outcome Scale (HoNOS), a clinician-rated outcome measure, is mandatory – albeit for clustering only. Mandating HoNOS use solely for clustering means that data only needs to be recorded once per patient.[86] To be effective as an outcome measure, HoNOS is reliant on recording of paired data (when two sets of HoNOS scales have been recorded for a patient – at admission and discharge, for example), which is not currently mandatory. As such, it is rarely used as a clinician-scored outcome measure, which is its primary purpose.

Paired scoring is easy to do within existing capacity and would enable assessment of which types of presenting issues have which types of outcomes, thus facilitating development of more specific measures in due course. It should be done as a minimum.

Although some trusts are making better progress than others, recording of paired data in HoNOS is generally poor across acute and crisis mental health services. According to MHSDS data, average paired measurement rates in HoNOS reporting are 33% for EIP, and 28% for both CRHTs and inpatient services. This means that outcomes cannot be identified in the majority of cases. Even where paired data does exist, it is not clear where and when such data is collated, analysed and fed back to services and boards. The variation in paired data among trusts is huge, especially in CRHT and inpatient reporting.

We are not suggesting that HoNOS is the only clinician rated outcome measure – for example, a number of Psychiatric Liaison services use Psychiatric Liaison Accreditation Network metrics; another promising initiative is the Commissioning for Quality and Innovation (CQUIN) framework, although the COVID-19 pandemic has led to the roll-out of CQUIN being suspended until March 2021.[87,88] However, the use of HoNOS is currently mandated (albeit limited to clustering) and routinely available in all electronic patient records, and so should remain the focus of use, analysis and reporting until better alternatives become widely available.

In relation to routine patient-reported outcome measures, the GIRFT survey revealed a similar overall lack of systematic data collection, analysis and reporting. Many trusts have told us that they are at various stages of looking at DIALOG+, a patient-reported measure of satisfaction with treatment and quality of life, as a co-produced outcome measure.[89] However, at the time of the GIRFT deep-dives, no trusts had any outcome data to show from such work.

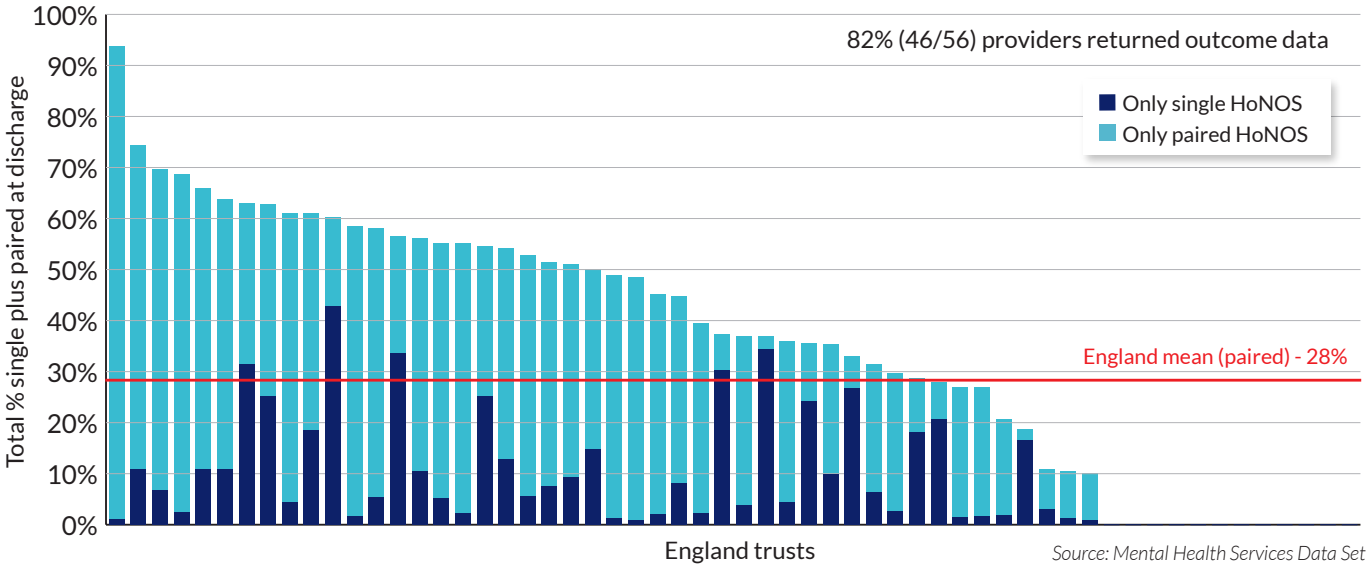
[86] *Royal College of Psychiatrists, 2020. Health of the Nation Outcome Scales (HoNOS). www.rcpsych.ac.uk/events/in-house-training/health-of-nation-outcome-scales*

[87] *Psychiatric Liaison Accreditation Network, 2020. Psychiatric Liaison Accreditation Network (PLAN) www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/psychiatric-liaison-accreditation-network-plan*

[88] *NHS England and NHS Improvement, 2020. 2020/21 CQUIN. www.england.nhs.uk/nhs-standard-contract/cquin/cquin-20-21/*

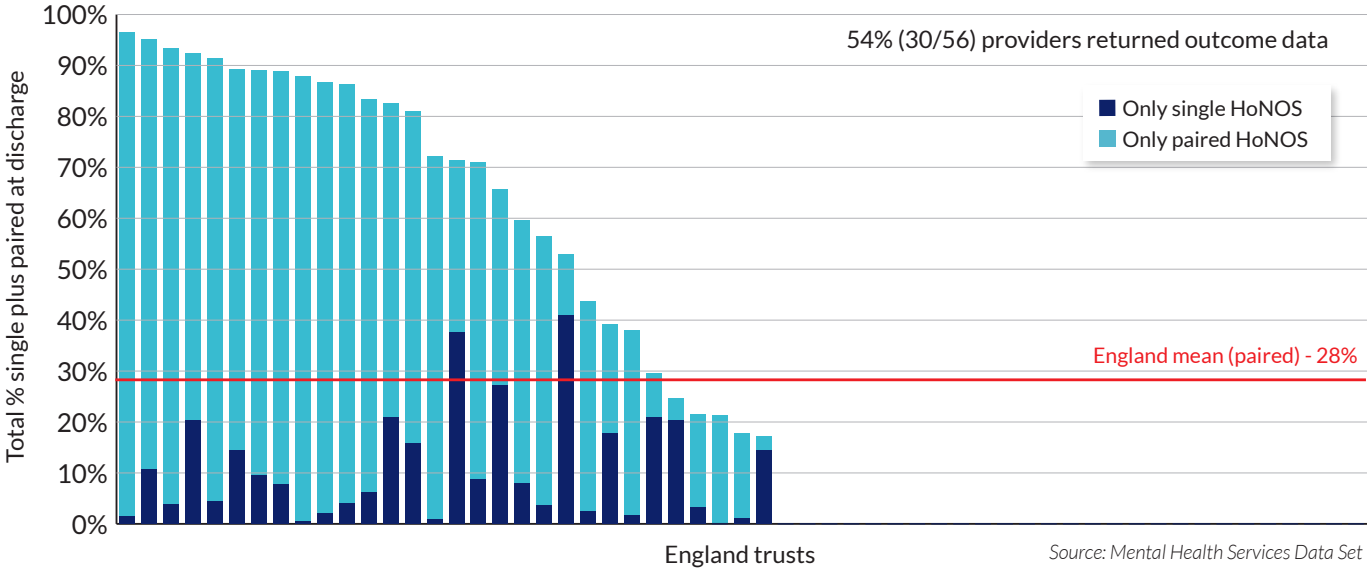
[89] *NHS East London Foundation Trust, 2016. DIALOG scale. https://dialog.elft.nhs.uk/DIALOG-scale*

*Figure 31a: Completed HoNOS ratings for discharge from CRHT, 2018/19*




*Source: Mental Health Services Data Set*

*Figure 31b: Completed HoNOS ratings for discharge from inpatient, 2018/19*

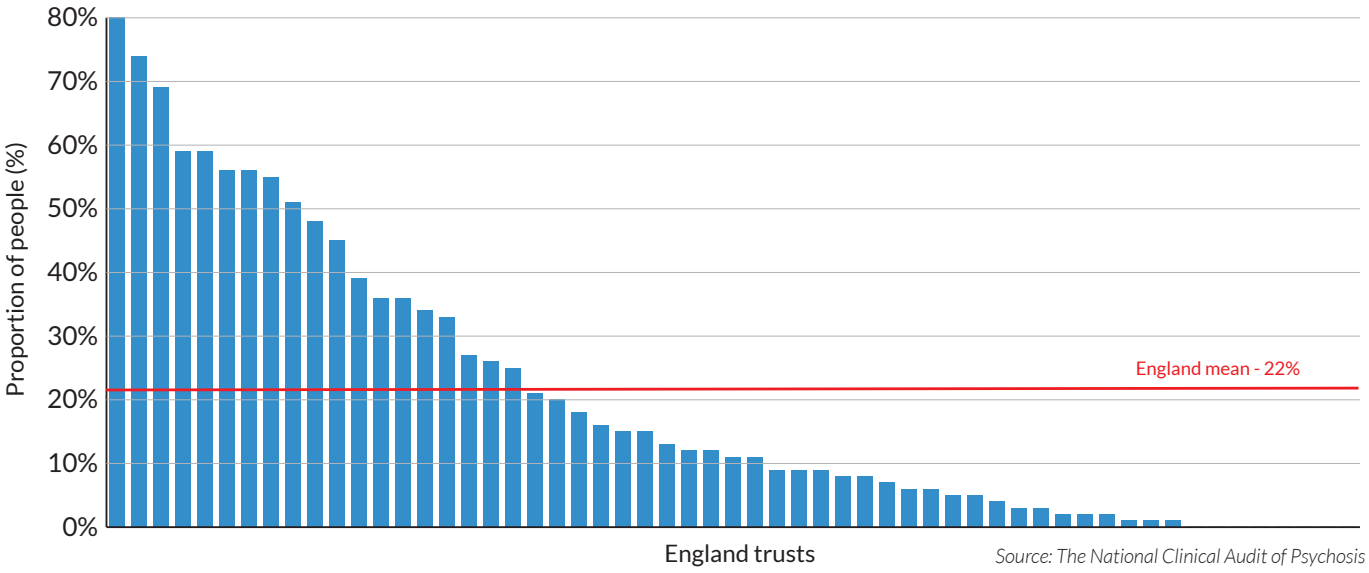



*Source: Mental Health Services Data Set*

NHS England and NHS Improvement recommend that HoNOS, DIALOG+ and the Process of Recovery Questionnaire (QPR) are used to measure patient outcomes in EIP. However, even though outcome data should be recorded as part of the patient's electronic care record and submitted as part of routine MHSDS collection, many trusts do not routinely do this. For example, only 5% of providers submitted adequate outcome data to MHSDS for 2018/19, while 86% of providers returned data as part of an NCAP case note audit. As seen in **Figure 32**, the NCAP data demonstrated generally low but varied levels of adequate recording of data.

The MHSDS is designed to enable the routine capture and reporting of information regarding referral to response, assessment and treatment times; interventions delivered (and whether they are in line with NICE recommendations); and clinician- and patient-reported outcomes. Issues with quality and completeness of data exist broadly in the MHSDS, of which HoNOS, DIALOG+ and QPR are all part of.[90]

***Figure 32: Percentage of people with first-episode psychosis for whom clinical outcome measurement data for patients (two or more outcome measures from HoNOS/HoNOSCA, DIALOG, QPR) is recorded at least twice (assessment and one other time point), 2018/19***




*Source: The National Clinical Audit of Psychosis*

The NHS LTP Mental Health Implementation Plan places an expectation on providers to improve the quality of data, particularly in terms of data flow to the MHSDS. Where outcome data is being reported, it is often not being analysed, although performance on this front varies from trust to trust. In terms of process measures, there is a reasonable amount of data, but the quality is inconsistent. Linkages between process data and interventions and outcomes are currently lacking.

An absence of robust data makes it difficult to make a definitive assessment of crisis care across and within trusts. Responses to the GIRFT questionnaire reveal significant inconsistencies in collecting and assessing access and outcomes data for specific patient groups.

There is scope for further development of the Model Hospital tool, including incorporation of GIRFT questionnaire data. It is important that Model Hospital is populated by routinely collected data from MHSDS, so as to avoid multiple data-collection processes running concurrently.

[90] *Neil, S.T., Pitt, L., Kilbride, M., et al, 2014. The Questionnaire about the Process of Recovery (the QPR): Guidelines for Clinicians, Researchers and Service Users for the uses, administration and scoring of the QPR. www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/early-intervention-in-psychosis-teams-(eipn)/eipn-questionnaire-about-the-process-of-recovery-15-item.pdf?sfvrsn=a754873b_2*

## Patient-centred care

A focus on patient-centred care is a commitment of NHS England and NHS Improvement that is explicitly backed by policy. Patient-centred care in the NHS means giving patients the power to manage their own health and make informed decisions about their care and treatment, while supporting them to improve their health and lead the life that they want.

In practice, this manifests most clearly in the form of patient care and support plans guided by an initial assessment conducted between a clinician and the patient, or, for those lacking capacity, following best-interest guidance. It can also often be valuable to the person and to service planning if, with their agreement, other key people such as family members can contribute to care planning. This process would be significantly enhanced if people were given up to date information on the risks and benefits, and especially the likely outcomes, of any proposed interventions specific to that service and team. Mental health currently lags behind a number of physical health specialities in regard to this.

In addition, patient experience and feedback is collected in piecemeal ways, such as complaints, compliments, the Friends and Family Test, and randomised surveys, such as CQC patient surveys. Response rates to such measures are generally low, as well as greatly variable.

Engagement activities are important for challenging the system; sampling of individual personal experiences provides different perspectives to those of care providers, but the subjects of such samples typically only represent a very small percentage of people accessing services. Although limited in numbers, however, all such feedback remains valuable, so it is essential that it is reviewed and disseminated to teams in a timely manner.

To more accurately gauge impacts and effectiveness, routine generation and use of patient outcome data for all people in contact with a service is essential. This will not replace other activities such as engagement events or external sampling; instead, they will together contribute to a more robust and comprehensive picture.

***Table 14: Current available patient experience data in mental health services in England. The majority are based on small samples, reinforcing the importance of routine outcome recording***

| Patient experience | Median | Range | N providers |
|---|---|---|---|
| Percentage of written complaints resolved in a timely manner | 52.1% | 18.8% and 98.6% | 60.7% (34/56) |
| Overall Experience Score for CMHT patient survey | 68.9% | 35.0% and 88.0% | 94.6% (53/56) |
| Friends and family test – % positive patient satisfaction scores | 91.0% | 68.0% and 98.0% | 89.3% (50/56) |
| Number of compliments the adult acute service has received per 100k occupied bed days | 183 | 2 and 2054 | 73.2% (41/56) |
| Mental health services – number of complaints per 100K weighted population (2018/19) | 17 | 5 and 59 | 87.5% (49/56) |

At odds with the NHS England and NHS Improvement commitment to providing patient-centred care, measures to do so are not routinely demonstrated in mental health care. The aforementioned variation in the proportion of patients receiving a copy of their assessment is one example. In addition to preventing inaccuracies creeping into the factors that affect care decisions, sharing of assessments ensures that care meets the 'nothing about me without me' criteria. It also empowers patients to retain their assessment and share it with other mental health providers in future, therefore reducing wasteful and often distressing repeat assessments to glean the same information.

One positive, actionable relevant measure included in the NHS LTP is the roll-out of NHS-wide policies related to personalised care. As part of this, the introduction of Personal Health Budgets will be accelerated to give people greater choice and control over how care is planned and delivered. In addition, 900,000 people will benefit from social prescribing by 2023/24; priority cohorts can include patients of mental health services.

## Restrictive practices

The use of restrictive practices in mental health inpatient care is intended only as a last resort when the safety of the patient and others cannot otherwise be guaranteed. It should be used sparingly. However, evidence suggests that the use of restrictive practices varies hugely across providers. Whereas the aim is to reduce harm, the reality is that – as with any type of intervention – restrictive practices may at times cause harm; this is more likely with certain types, such as prone restraint. In particular, there is huge variation in the use of restraint and prone restraint that is not explainable with current data.

One key issue around the use of restrictive practices is knowledge about their correct use. An interim report published by the CQC in 2019 found that many staff lacked the necessary training and skills with which to manage 'difficult patients'.[91] The report also found evidence that staff are not recording all incidents of restraint, and are not always documenting or recording seclusion or long-term segregation as required by the Mental Health Act Code of Practice.

CASE STUDY

### Safe wards

#### Herefordshire and Worcestershire Health and Care NHS Trust

Herefordshire and Worcestershire has introduced 'safe wards' across its mental health wards. This approach identifies interventions that can minimise conflicts within the ward environment and encourage positive interactions with patients. One of the key aims is to ensure that any physical interventions are utilised as a last resort and are facilitated safely.

#### A focus on staff training and involving patients in their care

The safe wards model is training-focused, and includes ten modules to enhance staff communication skills and support the creation of a therapeutic relationship and environment. The trust has also established an education drive across the pathway on the use of physical interventions.

As a result, the trust's mental health teams take a holistic approach when formulating interventions within Care and Treatment Plans. A focus on mutual expectations allows teams to capture the patient's wishes as well as their own, which creates a culture where patients and care teams work together.

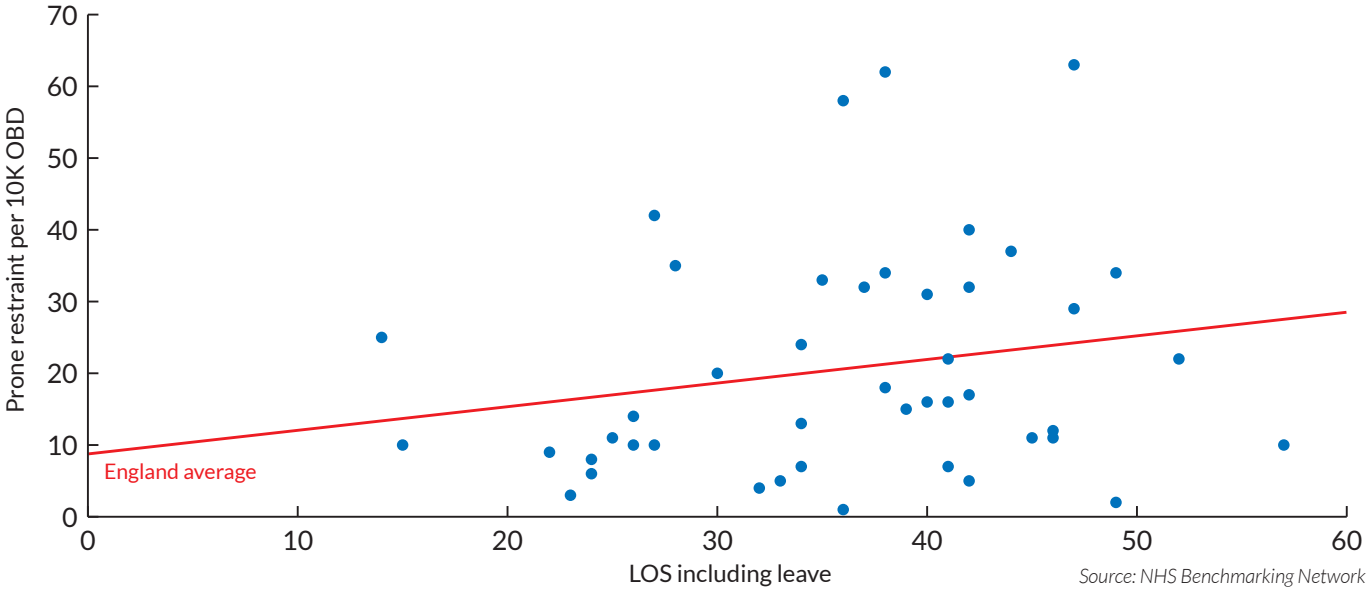
The use of safe wards has upskilled the staff in alternative strategies and interventions to utilise in supporting patients.

There have been zero reports of prone restraint across the trust's acute mental health wards.

Although much of the focus around restrictive practice is placed on the conditions and treatment within care facilities, there is also evidence that unnecessary length of stay can be a factor. According to the CQC interim report, some patients faced prolonged time in segregation due to delayed discharge from hospital arising from a lack of suitable non-hospital care options. NHSBN data for 2018/19 also suggests that the use of prone restraint may increase in step with length of stay.

[91] *Care Quality Commission, 2019. Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism. www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people*

***Figure 33: Adult acute length of stay and prone restraint per 10,000 occupied bed days, 2018/19***




*Source: NHS Benchmarking Network*

Guidance published by the Department of Health in 2014 emphasises the need for 'positive and proactive approaches' that leave use of restrictive practices as only a last resort to be used for the shortest possible time.[92] The guidance identifies six key principles:

- Compliance with the relevant rights in the European Convention on Human Rights at all times.
- Understanding people's behaviour allows their unique needs, aspirations, experiences and strengths to be recognised and their quality of life to be enhanced.
- Involvement and participation of people with care and support needs, their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations.
- People must be treated with compassion, dignity and kindness.
- Health and social care services must support people to balance safety from harm and freedom of choice.
- Positive relationships between the people who deliver services and those they support must be protected and preserved.

Despite the publication of the Department of Health guidance, there remains great variation across the country in how frequently staff restrain patients whose behaviour they find challenging. This wide variation is present even between wards that admit similar patient groups.

There are concerns that COVID-19 responses may have led to an increase in the use of restrictions. For example, it did lead to reduced visiting and reduced leave from acute inpatient units during the full first lockdown phase of the national response to COVID-19. Attempts to at least partially mitigate this with use of technology were positive, albeit often hampered by poor connectivity arising from the low historic investment in IT infrastructure in mental health services.

There has been positive recent progress on reducing restrictive practices, in the form of the Reducing Restrictive Practice Collaborative (RRPC). This programme was established by the National Collaborating Centre for Mental Health and NHS Improvement as part of the Mental Health Safety Improvement Programme, with the aim of addressing the concerns raised in the CQC interim report and to reduce the use of restrictive practice (restraints, seclusion and rapid tranquilisation) by one-third by April 2020.[93]

Nine months into an 18-month pilot of the RRPC conducted in 38 wards, the Royal College of Psychiatrists reported that reductions in the use of restrictive practices had been reported in 21 wards, with some wards achieving reductions of 88%.

[92] *Department of Health, 2014. Positive and Proactive Care: reducing the need for restrictive interventions. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf*

[93] *Reducing Restrictive Practice Collaborative, 2020. Reducing Restrictive Practice Collaborative. Royal College of Psychiatrists. www.rcpsych.ac.uk/improving-care/nccmh/reducing-restrictive-practice*

CASE STUDY

### Reducing restrictive practices in older people's inpatient services

**Surrey and Borders Partnership NHS Foundation Trust**

A long-running commitment by Surrey and Borders to the Positive and Safe agenda has resulted in reductions in restraint and restrictive practices. While national funding for Positive and Safe ceased in 2017, a trust-wide steering group continues to meet on a bi-monthly basis, and the trust says that positive behaviour support (PBS) remains central to its core ethos.

In order to monitor the presence and quality of care plans, the trust completed two audits of PBS plans within older people's mental health. The trust has also established 'PBS champions' within older people's mental health and offered bespoke training and coaching opportunities to these clinicians.

The trust cites clear gains from using the approach in older people's services, including:

- reductions in the use of restrictive practices;
- a significant shift in staff attitudes towards the Positive and Safe agenda;
- greater MDT ownership, and improved confidence in writing and implementing PBS plans.

A recent audit on restraint usage across Surrey and Borders services used a restraint case from an older people's ward as an example of good practice in terms of reporting, recording and carrying out the restraint.

## Dormitory accommodation

An important aspect of improving people's experience of acute inpatient care is the physical structure and functionality of the ward environment. In early 2020 around half of all mental health trusts were still using at least some dormitory accommodation. The adverse impacts of this are well known, and we are delighted that the NHS has set out a commitment to replace dormitories with more appropriate facilities. Ideally, the replacement facilities will come in the form of single, en-suite rooms.

Coupled with the capital investment needed to improve IT infrastructure and services within mental health services, improved ward settings will facilitate more therapeutic environments, and better ways of keeping people connected with their local teams and communities when they do require inpatient admission.

## Qualitative indicators for good practices and outcomes

In addition to inconsistencies in patient-centred practices and the use of patient experience measures, trusts tend to record negative outcomes, but not positive ones. For example, while considerable data is available on restrictive practice, some trusts do not routinely record compliments. This presents a limited picture, as improvements are more likely to be achieved if people know what good practice looks like, rather than only being told what bad practice looks like.

It is important that trusts capture and report all types of outcome and learn from good practice, as well as from instances when things go wrong. Staff morale (as well as recruitment and retention levels) and positive therapeutic impact tend to be higher when workers know that the culture is one of improvement and respect, rather than one in which fear culture drives protective practices.

Ultimately, the range of outcome measures should be expanded to provide a more honest, balanced picture of care. This will help to both improve morale and demonstrate good practice.

## Looking ahead

Outcome measurement has been much talked about over several decades without effective systems materialising. One issue that has held back progress has been conflating measures of whole system impact and measures of what mental health services can actually deliver. Routine outcome measurements should include triangulation of clinician- and patient-reported outcome measures and patient experience scores. Outcomes need to be linked to the purpose of the person receiving a specific intervention.

Demonstrating the positive outcomes of services will help to reduce stigma and improve timeliness of access. Equally, sometimes things can go wrong or not deliver the benefits that were sought. At present, trust board papers are typically better at reporting negative outcomes than routine and positive ones. Negative outcomes are important indicators, but learning from experience based only upon what did not work well is skewed and prevents services from building on what does work well.

Another key area is the duplication of data and the unnecessary repetition of processes to collect it. Trusts currently submit large amounts of data to multiple bodies. Given the limited capacity of trusts to collect, analyse and share data, it is essential that they should not need to submit similar but slightly different data to multiple organisations. Submission of so much data is only justifiable if it is analysed, fed back and used to improve services.

Finally, system-wide linkages must be developed in terms of outcomes measurement, assessment and reporting. Only then can a clear picture be gathered of the effectiveness of all the constituent parts of the service – both those provided by NHS mental health services and those that fall to the wider array of system partners who play some role in dealing with SMI in England.

## Recommendations

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **14.** Trusts need to capture and analyse the impact of all interventions to assess risks and benefits as part of evidence-based practice. | **a** Trusts to work with system partners and use technological advances to develop robust systems for capturing and reporting the use and impact of interventions – both unwanted outcomes (whether harmful or not) and achievement of desired beneficial outcomes – on an intent to treat basis. | Trusts with support from GIRFT, NHS X, NHS Digital, NHS England and NHS Improvement | For progress within 12 months of publication |
| **15.** Trusts need to increase awareness of whether variation is warranted or unwarranted. | **a** Trusts to promote positive variation in terms of better/best practice as it relates to the specific trust.<br>**b** Where variation in intervention or outcome relates to not using best, evidence-based practice such as Clozapine or CBTp or Family Intervention in line with NICE guidance, trusts to review reasons for this (including with system partners, if necessary).<br>**c** Trusts to reduce unwarranted variation using guidance such as in LTP EIP services recommendation on increasing NICE concordance.<br>**d** Trusts to flag unwarranted variation to the ICS/STP and PCN where it is due to factors outside of trust control. | Trusts with support from GIRFT, NHS England and NHS Improvement, ICS/STPs | For progress within 12 months of publication |
| **16.** Trusts need to develop and report robust ways for capturing interventions and outcomes for services that are heavily linked into partnership working (for example, psychiatric liaison offers a range of ways of working with acute hospitals over and above work in urgent and crisis care, older-adult services link into wider initiatives such as Ageing Well/frailty programmes, and crisis response services are typically multi-agency linked). | **a** Trusts to work with system partners to develop robust ways for capturing and reporting the contribution by trust-based services interventions and outcomes to the overall system responses to improving health and wellbeing of people with SMI. | Trusts with support from GIRFT | For progress within 12 months of publication |

# Litigation

## Reducing the impact of litigation

Each of the GIRFT programme teams has been asked to examine the impact and causes of litigation in their field with a view to reducing the frequency of litigation and, more importantly, reducing the incidents that lead to it. It is important for clinical staff have the opportunity to learn from claims in conjunction with learning from complaints, serious untoward incidents (SUIs)/serious incidents (SIs)/patient safety incidents (PSI) and inquests will lead to improved patient care and reduced costs both in terms of litigation itself and the management of the resulting complications of potential incidents.

It was clear during GIRFT visits that many providers had little knowledge of trends in the claims against them. As a consequence, the opportunity to learn from the claims to inform future practice is lost. Further work is needed at both a local and national level to analyse claims to maximise this opportunity to improve patient care.

## Variation in average litigation costs

Data obtained from the NHS Resolution shows that clinical negligence claim costs in adult mental health related claims are detailed in **Table 15**. There has been no significant change on the numbers of claims, other than an increase in the financial year 2017/18, when there was a corresponding change in claims costs. The claims cost increase in the financial year 2017/18 was mostly due to a small number of high-cost claims that skewed the trend upwards. With this type of data, the use of run charts and SPC to monitor fluctuations and trends over time is essential.

***Table 15: Volume and cost of medical negligence claims related to adult mental health notified to NHS Resolution, 2013/14–2017/18.***

| Year of notification | No. of claims | % change in claims | Sum of Total Claim (£) | % change in cost |
|---|---|---|---|---|
| 2013/14 | 255 | - | 36 million | - |
| 2014/15 | 218 | -15% | 34 million | -5% |
| 2015/16 | 230 | +6% | 36 million | +5% |
| 2016/17 | 227 | -1% | 27 million | -25% |
| 2017/18 | 270 | +19% | 56 million | +105% |
| **Grand Total** | **1200** | **-** | **190 million** | **-** |

## Claims trends and causes

### Suicide

When a person takes their own life it has a devastating, lifelong impact on the family, carers and staff involved in that person's care. As shown in **Table 16**, the number of clinical negligence claims relating to suicide is small, but it does account for over one-fifth of the number of adult mental health claims and over a quarter of the estimated potential costs associated with these claims.

The NHS Resolution Safety and Learning Team undertook further thematic analysis of claims related to suicide to better understand the clinical and non-clinical themes in care from attempted and completed suicide that resulted in a claim for compensation.[94] Their analysis demonstrated that recurrent themes were consistent through many of the incidents associated with these claims, including poor management of substance misuse, difficulties with community services (especially in inter-agency working), inaccurate and poorly documented risk assessments, and inconsistent observation

[94] *Oates, A., 2018. Learning from suicide-related claims: A thematic review of NHS Resolution data. NHS Resolution. https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/*

processes. Furthermore, the serious incident investigations that followed the incident in these claims often lacked the involvement of the family, and the reports that were produced lacked robust recommendations that were consequently unlikely to impact on future practice. The NHS Resolution report produces nine recommendations that guide mental health departments to improve clinical and non-clinical practice in this area and focus on a systematic approach to communication through all bodies involved in patient care in mental health.

***Table 16: Volume and cost of suicide related medical negligence claims notified to NHS Resolution, 2013/14–2017/18***

| Year of notification | No. of claims | % change in claims | Sum of Total Claim (£) | % change in cost |
|---|---|---|---|---|
| 2013/14 | 53 | - | 9 million | - |
| 2014/15 | 54 | 2% | 9 million | 5% |
| 2015/16 | 38 | -30% | 12 million | 27% |
| 2016/17 | 53 | 39% | 9 million | -26% |
| 2017/18 | 52 | -2% | 19 million | 119% |
| **Grand Total** | **250** | **-** | **57 million** | **-** |

***Table 17: The top six most frequent causes for litigation in adult mental health, 2013/14–2017/18***

| Causes | No. of claims | % of total claims |
|---|---|---|
| Treatment | 329 | 28% |
| Self-harm | 165 | 14% |
| Unexpected death | 127 | 11% |
| Failure to supervise | 101 | 8% |
| Medication errors | 79 | 7% |
| Inadequate nursing | 72 | 6% |

## Causes

Using the NHS Resolution data, common causes for litigation in adult mental health were identified. It is important to note that more than one cause can be assigned to each claim. It is recognised that many claims may be reasonably attributed to areas of the healthcare system that require improvement.[95] Some of the claim cause codes, including failure to supervise, medication errors and inadequate nursing, suggest further scrutiny of claims that feature these codes will enable clinical staff to learn and improve delivery of care.

[95] *Kaplan, C., 2006. Reducing Risk in Mental Health Services: the Work of the NHS Litigation Authority. Mental Health Review Journal, 11 (1); pp.34–37.*

| Recommendation | Actions | Owners | Timescale |
|---|---|---|---|
| **17.** Reduce litigation costs by application of the GIRFT programme's five-point plan. | **a** Clinicians and trust management to assess their litigation claims covered under Clinical Negligence Scheme for Trust (CNST) notified to the trust over the last five years. | Trusts, GIRFT | For immediate action |
| | **b** Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via *CNST.Helpline@resolution.nhs.uk* | Trusts, GIRFT | Upon completion of action a |
| | **c** Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support | Trusts, GIRFT | Upon completion of action b |
| | **d** Claims should be triangulated with learning themes from complaints, inquests and serious untoward incidents (SUI)/serious incidents (SI)/Patient Safety Incidents (PSI) and where a claim has not already been reviewed as SUI/SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all staff in a structured format at departmental/directorate meetings (including multidisciplinary team meetings, Morbidity and Mortality meetings where appropriate). | Trusts, GIRFT | Upon completion of action c |
| | **e** GIRFT clinical leads and regional hubs to share with trusts examples of good practice where it would be of benefit. | Trusts, GIRFT | For continual action throughout GIRFT programme. |

# Financial impacts and opportunities

Significant investment in alternative services would create an opportunity to create better value and improve the quality of mental health adult crisis and acute care. Where adult mental health is proactively managed locally to provide earlier interventions, acute care costs could be reduced, and outcomes improved. The aim should be to ensure that timely access to an inpatient bed is available to everyone for whom admission is essential, thus avoiding 'turn-aways' and the risk of serious harm.

To help support this required investment, acute hospital beds should be used more appropriately and consistently (various recommendations and best practice case studies are shown in this report). **Figure 29** on page 74 which looks at 'super-stranded' patients (90+ days length of stay) highlights that, for many, opportunities are being missed earlier in the care pathway. If all adult acute and crisis mental health length of stay met the national average (about 32 days) and appropriate earlier interventions and alternative services were offered to all who required them, the potential gross financial opportunity could be in the region of £125m.

The table below includes examples of areas identified within the national report where there is potential to make significant changes that could contribute to an overall reduction in acute bed days. The examples are not mutually exclusive – there is overlap between them – and they may also duplicate elements identified as opportunities within other GIRFT national reports related to reductions in length of stay.

In addition to the specific areas outlined in the table, we have identified a total spend of £190m on litigation over a five-year period. Implementation of the GIRFT Programme's five-point plan should improve patient safety and reduce litigation costs linked to adult mental health crisis and acute services.

***Table 18: Financial opportunities linked to mental health crisis and acute services.***

| Improvement | Standard | | | Target | | |
|---|---|---|---|---|---|---|
| | Target | Activity opportunity* | Gross notional financial opportunity** | Target | Activity opportunity* | Gross notional financial opportunity** |
| **Improve community-based care and local inpatient capacity** *(recommendation 4)* | *Clinical view* | | | *Clinical view* | | |
| Opportunity: Reduce out of area placements over 50km<br>*Base data: April 18–Mar 19.*<br>*Cost estimated based on 25% of average admitted MH care cluster (MHCC currencies) admission cost – derived from bed-day cost (18/19 ref costs uplifted to 20/21 prices). Assumes an estimated 25% of admission cost could be avoided if patients did not go out-of-area* | 50% reduction in OA placements | 2800 admissions | £8.64m | 70% reduction in OA placements | 3900 admissions | £12.03m |

*Table 18: Financial opportunities linked to mental health crisis and acute services.*

| Improvement | Standard | | | Target | | |
|---|---|---|---|---|---|---|
| | Target | Activity opportunity* | Gross notional financial opportunity** | Target | Activity opportunity* | Gross notional financial opportunity** |
| **Ensure existing staff capacity is efficiently utilised and train sufficient numbers of professionally qualified staff** *(recommendations 5 and 7)*<br>Opportunity: Reduce bank and agency costs<br>*Base data: April 18–Mar 19 (GIRFT adult MH questionnaire)*<br>*Based on Total Bank and Agency costs reported in GIRFT MH questionnaire (Sep 2019)* | *Clinical view*<br>5% reduction in MH staff bank and agency spend | | £7.64m | *Clinical view*<br>10% reduction in MH staff bank and agency spend | | £15.27m |
| **Reduction in patients that present to A&E 24 hours or less, prior to admission** *(recommendation 10)*<br>Opportunity: Reduce A&E attendances<br>*Base data: April 18–Mar 19*<br>*Cost estimated based on average A&E non admitted attendance cost (18/19 ref costs uplifted to 20/21 prices)* | *National average*<br>23.9% adult MH Patients seen in A&E less than 24hrs prior to admission | 4600 A&E attendances | £0.54m | *Best quartile*<br>16.2% adult MH Patients seen in A&E less than 24hrs prior to admission | 9900 A&E attendances | £1.17m |
| **Reduce unexplained variation in admissions under the Mental Health Act** *(recommendations 10 and 11)*<br>Opportunity: Reduce admissions under the Mental Health Act<br>*Base data: April 18–Mar 19.*<br>*Cost estimated based on 75% of average adult secure MH (SMH currencies) admission cost – derived from bed day cost (18/19 ref costs uplifted to 20/21 prices), on the basis that 75% of admission cost could be avoided* | *National average*<br>42.8% MHA admissions | 4200 admissions | £38.87m | *Best quartile*<br>39.1% MHA admissions | 5700 admissions | £52.76m |

*Table 18: Financial opportunities linked to mental health crisis and acute services.*

| Improvement | Standard | | | Target | | |
|---|---|---|---|---|---|---|
| | Target | Activity opportunity* | Gross notional financial opportunity** | Target | Activity opportunity* | Gross notional financial opportunity** |
| **Most short-stay hospital cases could and should receive better care in the community** *(recommendation 11)* | *National average* | | | *Best quartile* | | |
| Opportunity: Reduce proportion of short stay hospital admissions (0-3 days LOS) *Base data: April 18–Mar 19.* *Cost estimated based on average admitted MH care cluster (MHCC currencies) bed day cost x 2 (18/19 ref costs uplifted to 20/21 prices, on assumption that 2 bed days would be saved per short stay admission avoided* | 14.3% short stay acute admissions – stays 0-3 days | 1700 bed days | £1.47m | 9.3% short stay acute admissions – stays 0-3 days | 4100 bed days | £3.54m |
| **Ensure people do not become stranded in community teams or inpatient services** *(recommendation 11, bullet point 4)* | *National average* | | | *Best quartile* | | |
| Opportunity: Reduce length of stay of patients staying over 60 days *Base data: April 18–Mar 19.* *Cost estimated based on average admitted MH care cluster (MHCC currencies) bed day cost (18/19 ref costs uplifted to 20/21 prices. Assumes a reduction of 28 bed days per 'stranded' admission where length-of-stay is reduced to 60 days or below (60 less 32 days national average LOS)* | 14.3% stranded inpatients – stays over 60 days | 44500 bed days | £19.19m | 10.6% stranded inpatients – stays over 60 days | 93300 bed days | £40.24m |
| **Total** | | | **£76.35m** | | | **£125.01m** |

* Activity opportunities are annual figures, based on one year of activity data (2018/19). Unless specified, activity that could be avoided is shown

** Costing of financial opportunity: unless otherwise stated, cost estimates are based on national average 2018/19 reference costs, uplifted to 2020/21 pay and prices using tariff inflation

# About the GIRFT programme

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS.

Funded by the Department of Health and Social Care and jointly overseen by the Royal National Orthopaedic Hospital NHS Trust and NHS England and NHS Improvement, it combines wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal, they can, when multiplied across an entire trust – and even more so across the NHS as a whole – deliver substantial cumulative benefits.

The programme was first conceived and developed by Professor Tim Briggs to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics. In the 12 months after the pilot programme, it delivered an estimated £30m–£50m savings in orthopaedic care – predominantly through changes that reduced average length of stay and improved procurement.

The same model is now being applied in 40+ different areas of clinical practice. It consists of four key strands:

1. A broad data gathering and analysis exercise, performed by health data analysts, which generates a detailed picture of current national practice, outcomes and other related factors.
2. A series of discussions between clinical specialists and individual hospital trusts, which are based on the data –providing an unprecedented opportunity to examine individual trust behaviour and performance in the relevant area of practice, in the context of the national picture. This then enables the trust to understand where it is performing well and what it could do better – drawing on the input of senior clinicians.
3. A national report, that draws on both the data analysis and the discussions with the hospital trusts to identify opportunities for NHS-wide improvement.
4. An implementation phase where the GIRFT team supports providers to deliver the improvements recommended.

## GIRFT and other improvement initiatives

GIRFT is part of an aligned set of workstreams within NHS Improvement. It is the delivery vehicle for one of several recommendations made by Lord Carter in his February 2016 review of operational efficiency in acute trusts across England.

As well as support from the Department of Health and Social Care and NHS England and NHS Improvement, it has the backing of the Royal Colleges and professional associations.

GIRFT has a significant and growing presence on the Model Hospital portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The programme also works with a number of wider NHS programmes and initiatives which are seeking to improve standards while delivering savings and efficiencies, such as NHS RightCare, acute care collaborations (ACCs), and sustainability and transformation partnerships (STPs).

## Implementation

GIRFT has developed an implementation programme designed to help trusts and their local partners to address the issues raised in trust data packs and the national specialty reports to improve quality. The GIRFT team provides support at a local level, advising on how to reflect the national recommendations into local practice and supporting efforts to deliver any trust specific recommendations emerging from the GIRFT visits. GIRFT also helps to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice. Through all its efforts, local or national, the GIRFT programme strives to embody the 'shoulder to shoulder' ethos that has become GIRFT's hallmark, supporting clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

# Glossary

## Terminology

**Clozapine**
An antipsychotic medicine used to treat patients suffering from schizophrenia, ideally when other treatments have failed.

**Cognitive behavioural therapy (CBT)**
A talking therapy that can help people manage problems by changing the way that they think and behave. Commonly used to treat anxiety and depression.

**Discharge to assess**
Where clinically optimised patients who do not require an acute bed but may still require care services are provided with short-term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

**Dual diagnosis**
When a patient is diagnosed with both a mental health issue and another condition. Such conditions can include physical conditions or, for example, a learning disability, autism or dementia, among others.

**Joint Strategic Needs Assessment (JSNA)**
Looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services within a local authority area.

**Liaison psychiatry**
Liaison psychiatry services provide psychiatric care to medical patients, including those attending emergency departments and general hospital, and patients being seen in community and primary care medical services.

**Mental Health Act 1983**
The main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the MHA need urgent treatment and are at risk of harm to themselves or others.

**Mental Capacity Act 2005**
Designed to protect and empower people who may lack the mental capacity to make their own decisions about care and treatment.

**Out of area placement (OAP)**
When a patient is transferred to a facility outside of the local trust for inpatient treatment.

**Primary Care Network (PCN)/Integrated Care System (ICS)**
Geographically based partnerships of NHS organisations and other local stakeholders, such as local authorities, that collectively plan care to meet population needs. ICSs cover large areas (often exceeding county borders). PCNs are smaller, serving 30,000–50,000 people.

**Psychiatric Intensive Care Unit (PICU)**
A ward designed to provide care for patients who cannot be managed on other wards due to the risk that they pose to themselves or others.

**Psychosis**
When people lose some contact with reality. This might involve hallucinations and/or delusions.

**Restrictive practices**
Placing a patient in restraint or prolonged seclusion. Restraint can be both physical (by holding an individual or using equipment such as bed restraints) or medical (using sedatives, for example).

**Segmentation**
The categorisation of a population according to a variety of categories, including (but not limited to) demographics (age, ethnicity, gender, etc), health needs and health status.

**Serious mental illness (SMI)**
A blanket term for psychological problems, such as schizophrenia and bipolar disorder, that are often so debilitating that a person's ability to engage in functional and occupational activities is severely impaired.

## National organisations/bodies

### Health Education England (HEE)

The national leadership organisation for education, training and workforce development in the health sector.

*www.hee.nhs.uk*

### Mental Health Services Data Set (MHSDS)

Brings together information captured on clinical systems as part of patient care. It covers services provided in hospitals as well as in outpatient clinics and the community.

*www.content.digital.nhs.uk/mhsds*

### National Clinical Audit of Psychosis (NCAP)

A programme to increase the quality of care that NHS mental health services provide to people with psychosis.

*www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis*

### National Institute for Health and Care Excellence (NICE)

Provides national guidance and advice to improve health and social care.

*www.nice.org.uk*

### NHS Benchmarking Network (NHSBN)

A provider member network that conducts projects and work programmes to benchmark publicly funded health and social care services.

*www.nhsbenchmarking.nhs.uk/*

### NHS RightCare

NHS RightCare's function is to reduce unwarranted variation to improve people's health.

*www.england.nhs.uk/rightcare/*

# Acknowledgements

## Data and copyright acknowledgements

The GIRFT programme would like to thank the following organisations for making data publicly available:

- NHS Benchmarking Network
- NHS Digital
- The National Clinical Audit of Psychosis

We are grateful to NHS Resolution for the litigation data provided, and to John Machin and Annakan Navaratnam for their kind authorship of the litigation section in this report.



## GIRFT report team

With thanks also to:

Dr Ian Davidson – Clinical Lead;
Teresa Due – Review Project Manager;
Suzannah Davies – Review Project Manager;
Andrew Daniel – Policy Manager;
Craig Colling – Analytics Manager;
Paul Tucker – Editor;
Madeleine Connolly – GIRFT Senior Manager, Finance and Analytics;
Julie Renfrew – Principle Finance Analyst;
Matthew Barker – Senior Policy Lead;
Anna Woodford – Series Editor;
John Machin – Clinical Lead for Litigation;
Annakan Navaratnam – Clinical Fellow (Litigation);
Melanie Proudfoot – Head of Communications;
Michelle Carter – Communications and Media Relations Manager.

For more information about GIRFT,
visit our website: www.GettingItRightFirstTime.co.uk
or email us on info@GettingItRightFirstTime.co.uk

You can also follow us on Twitter @NHSGIRFT and
LinkedIn: www.linkedin.com/company/getting-it-right-first-time-girft

The full report and executive summary are also available to download as
PDFs from: www.GettingItRightFirstTime.co.uk


Design: www.andrewburdettdesign.com