NHS England

Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16

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Finance		

Publications Gateway Reference:	**02932**
Document Purpose	Guidance
Document Name	Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16
Author	NHS England / Medical Directorate / Mental Health Team
Publication Date	12 February 2015
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , Medical Directors, Directors of Nursing, NHS England Regional Directors, NHS England Area Directors, NHS Trust CEs
Additional Circulation List	CSU Managing Directors, Local Authority CEs, Directors of Adult SSs, NTDA, Monitor, HSCIC, CQC, DH, Mental Health Policy Group, NHS Providers, Health & Wellbeing Boards, LGA, SOLACE, All NHS
Description	Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Mental Health Team Medical Directorate Skipton House London SE1 6LH

Document Status

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Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16

Version number: 1

First published: 12 February 2015

Prepared by: NHS England

Classification: OFFICIAL

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1 Introduction

1.1 The new access and waiting time standards

In October 2014, NHS England and the Department of Health jointly published *Improving access to mental health services by 2020*[1]. This document outlined a first set of mental health access and waiting time standards for introduction during 2015/16 and set out an ambition, subject to future resourcing decisions following the next Spending Review, to introduce access and waiting time standards across all mental health services between 2016 and 2020. These commitments were reaffirmed in the NHS Mandate[2] and reflected in the joint planning guidance for 15/16, *Forward view into action 2015/16*[3].

Improvements towards meeting the first standards will come into effect from 1 April 2015 for achievement by 1 April 2016 and are focused in three areas where timely access to evidence-based care is of particular importance in improving longer term mental health, physical health and recovery-focused outcomes and in reducing the distress experienced by individuals and their families:

- More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. Most initial episodes of psychosis occur between early adolescence and age 25 but the standard applies to people of all ages in line with NICE guidance.

- 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. This standard applies to adults.

- £30m investment is to be targeted on effective models of liaison psychiatry in a greater number of acute hospitals. From 15/16, when the Care Quality Commission (CQC) rates acute services, it will include a specific focus on liaison mental health services and mental health care, as well as the quality of treatment and care for physical conditions. *Achieving better access to mental health services by 2020* set the expectation that, by 2020, all acute trusts will have in place liaison mental health services for all ages appropriate to the size, acuity and specialty of the hospital.

1.2 Supporting funding

The new standards for 15/16 will be supported by an £80m funding package:

- £40m recurrent funding to support delivery of the early intervention in psychosis standard;

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf
[2] https://www.gov.uk/government/publications/nhs-mandate-2015-to-2016
[3] http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

- £10m to support delivery of the IAPT standard (criteria for distribution in development); and
- £30m to support delivery of the liaison psychiatry standard (criteria for distribution in development).

In addition:

- The National Collaborating Centre for Mental Health (NCCMH) has been commissioned to develop national resources to support implementation. The NCCMH is the body responsible for developing mental health guidelines on behalf of the National Institute of Health and Care Excellence (NICE).
- Funding has been made available to support regional programmes of work aimed at ensuring robust preparedness for introduction of the early intervention in psychosis (EIP) standard (£200k per region).
- System resilience monies are being used in many areas to support preparedness efforts across EIP and liaison psychiatry services.

1.3 Expectations of commissioners and providers

The joint planning guidance, *Forward view into action 2015/16,* makes clear the requirement that commissioners should agree robust implementation plans with providers as part of their 15/16 contract development work.

- **For EIP and IAPT** commissioners are required to agree service development and improvement plans (SDIPs) as part of their 15/16 contract with mental health providers, setting out how providers will prepare for and implement the new standards during 2015/16 and achieve them on an ongoing basis from 1 April 2016.
- **For liaison psychiatry** commissioners will be required to agree SDIPs with acute providers, setting out how providers will ensure there are adequate and effective levels of liaison psychiatry services across acute settings. Supplementary planning guidance[4] made clear the expectation that all acute trusts should, by 2020, have in place effective models of liaison psychiatry (all ages, appropriate to the size, acuity and specialty of the hospital).
- **For IAPT** CCGs will be also be required to submit plans setting out how they will meet the new waiting time standards and these will be monitored throughout the year. Compliance will be assessed in the final quarter of 2015/16.

The supplementary planning guidance highlights the importance of meeting legal duties with regard to equality and health inequalities; this should be reflected in the development of local plans.

[4] http://www.england.nhs.uk/wp-content/uploads/2014/12/plan-guid-nhse-annx-231214.pdf

Monitor and the NHS Trust Development Authority (TDA) have highlighted the importance of prioritising achievement of the new standards in their planning frameworks for providers for 15/16[5][6]. Delivery of the new standards will require highly effective joint working between commissioners and providers during this first year of the access and waiting times programme, and over the course of the four years ahead.

1.4 Eating disorders

The Autumn Statement 2014 outlined the provision of additional funding of £30million recurrently for 5 years to be invested in a central NHS England programme to improve access for children and young people to specialist evidence-based community CAMHS eating disorder services. Part of this programme funding will be used to develop an access and waiting time standard.

The aims of the programme are to:

- Deliver swift access to evidence based community treatment for children and young people with eating disorders;
- Reduce demand for specialist inpatient beds;
- Reduce relapse;
- Reduce transfers to adult services and mitigate the problems of transition for young people with eating disorders when they turn 18 through the development of care pathways for children and young people up to the age of 25;
- Ensure a consistent evidence-based outcomes- focussed model of care;
- Through ringfenced investment in specialist eating disorder services, build capacity within general CAMHS so that a greater number of children and young people with other mental health problems, such as self harm, can access treatment; and
- Reduce inequalities in access to services and improve health outcomes for all who require care.

1.5 Purpose of this document

This document is intended to:

1. Clarify the requirements of each of the new 15/16 mental health access and waiting time standards and associated expectations of CCG commissioners in line with the planning guidance.

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386147/RAF_consultation_Dec_14.pdf
[6] http://www.ntda.nhs.uk/wp-content/uploads/2014/12/tda_planning_2014_final_web.pdf

2. Outline the intention to implement access and waiting time standards for eating disorders in community CAMHS from 2016.

3. Update commissioners, providers, commissioning support units, regional and sub-regional teams and wider system stakeholders regarding the national programme of support for implementation of the new access and waiting time standards.

4. Signpost the above stakeholders to helpful sources of regional support for implementation of the early intervention in psychosis standard.

1.6 Equality and health inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between individuals in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

Access and waiting time standards in mental health services must be implemented so as to ensure reduced inequity in access and improve outcomes for all who require care.

2 Early intervention in psychosis

2.1 The access and waiting time standard

The new access and waiting time standard requires that, by 1 April 2016, more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.

The standard is 'two-pronged' and both conditions must be met for the standard to be deemed to have been achieved, i.e.

1. A maximum wait of two weeks from referral to treatment; and

2. Treatment delivered in accordance with NICE guidelines for psychosis and schizophrenia - either in children and young people CG155 (2013) or in adults CG178 (2014).

Most initial episodes of psychosis occur between early adolescence and age 25 but the standard applies to people of all ages in line with NICE guidance.

2.2 Why set a standard?

In 2011, *No Health Without Mental Health*[7] highlighted the effectiveness of early intervention services for people experiencing first episode psychosis. There is good evidence that these early intervention in psychosis (EIP) services, when delivered in accordance with NICE standards, help people to recover from a first episode of psychosis and to gain a good quality of life:

- 35% of people under their care are in employment, compared with 12% in traditional care;

- They reduce the likelihood of an individual receiving compulsory treatment from 44% to 23% during the first two months of psychosis; and

- They reduce a young person's suicide risk from up to 15% to 1%[8].

NICE also found that these services reduce the likelihood that individuals with psychosis will relapse or be detained under the Mental Health Act, potentially saving the NHS £44 million each year through reduced hospital admissions[9].

It is well established that failure to engage and intervene effectively in early psychosis and its prodrome (precursor stages) leads to poorer outcomes for individuals and their families and high levels of consequent expenditure in both NHS

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
[8] http://www.rethink.org/media/973932/LOST%20GENERATION%20-%20Rethink%20Mental%20Illness%20report.pdf
[9] National Institute for Health and Care Excellence, 2014. Costing statement: Psychosis and schizophrenia in adults: treatment and management.

and other public services. The provision of evidence based care in the prodromal period can prevent the development of psychosis in a significant proportion of cases, preventing much illness, disability and distress to young people and their families.

We know that currently far too few individuals experiencing or at high risk of first episode psychosis are receiving the 'right care' at the 'right time' and there can be very long delays in accessing some of the key effective interventions recommended by NICE, particularly the recommended psychological therapies - CBT for psychosis and family therapy – but also physical healthcare interventions and employment support (e.g. individual placement and support schemes). These poor levels of access and long waits make very little sense in terms of either high quality care or effective use of NHS resources.

The high level aims of the new standard are therefore to ensure that:

1. Anyone with an emerging psychosis and their families and key supporters can have timely access to specialist early intervention services which provide interventions suited to age and phase of illness.

2. Individuals experiencing first episode psychosis have consistent access to a range of evidence-based biological, psychological and social interventions as recommended by the NICE guidelines for psychosis and schizophrenia in children and young people CG155 (2013) and in adults CG178 (2014) and the NICE guideline for psychosis with co-existing substance misuse.

3. Care is provided equitably - taking into account higher rates of psychosis in certain groups who may experience difficulties in accessing traditional services.

2.3 How will the standard be measured?

Both elements of the standard will be measured – the wait from referral to treatment and whether the treatment accessed is NICE concordant. Due regard will be paid in the development of the measurement approach to the importance of ensuring effective monitoring of equity of access relative to the levels and patterns of psychosis incidence in the population.

2.3.1 Measuring referral to treatment time (RTT)

Technical guidance for measurement of the standard is still under development but the expected approach is outlined in Appendix 1. This has been developed in collaboration with the EIP Expert Reference Group hosted by the National Collaborating Centre for Mental Health.

2.3.2 Assessing NICE concordance

The approach to measurement will be necessarily retrospective. For year 1, the approach currently being explored is the commissioning of a national clinical audit focusing on the care offered and delivered to individuals identified as experiencing first episode psychosis during 2015/16.

By April 2016, the mental health and learning disability dataset (MHLDDS) is to be updated to include the relevant NICE concordant interventions so that it should be possible in the medium term to draw the relevant data directly from provider systems.

A third option under development is the establishment of an accreditation or service ‘kitemarking’ scheme for early intervention in psychosis services.

2.4 Data collection approach

NHS England has worked with the EIP Expert Reference Group, hosted by the National Collaborating Centre for Mental Health (NCCMH) to specify the developments required to the MHLDDS to enable capture of the data required to measure both elements of the EIP standard. The dataset changes are expected to take effect before 1st April 2016.

As described in section 2.3.2 above, national clinical audit will be the likely approach for assessing NICE concordance during 15/16.

2.5 Expectations of commissioners

The planning guidance for 15/16, *Forward view into action 2015/16* requires that commissioners should agree plans with providers setting how they will prepare for and implement the new standard during 2015/16 and achieve it on an ongoing basis from 1 April 2016. Commissioners are required to agree service development and improvement plans (SDIPs) as part of their 15/16 contract.

NHS England’s expectation is that the additional £40m funding being made available recurrently (see section 1.2) should be invested recurrently in EIP services to support sustainable delivery of the new access and waiting time standard. EIP services are subject to local agreement on pricing, and so commissioners should ensure that increases in the level of local investment take into account baseline performance against both elements of the EIP standard:

- Referral to treatment waiting times; and
- Current levels of NICE concordance – access to the range of evidence-based biological, psychological and social interventions as recommended by NICE guidelines for psychosis and schizophrenia in children and young people CG155 (2013) and in adults CG178 (2014).

The supplementary planning guidance highlights the importance of meeting legal duties with regard to equality and health inequalities; this should be reflected in the development of local plans.

2.6 National resources to support implementation

The National Collaborating Centre for Mental Health (NCCMH) has been commissioned to develop national resources to support implementation. Its programme will comprise the following key elements:

1. Hosting and running the national EIP Expert Reference Group, bringing together expert clinical and system stakeholders including experts by experience, operational leads, CCG GP MH leads, strategic clinical network (SCN) and academic health sciences network (AHSN) representatives.

2. Supporting the work of regional implementation steering groups.

3. Specification of the dataset required to enable: reporting of a clinically-informed referral to treatment (RTT) pathway, assessment of NICE concordance, evaluation of treatment outcomes.

4. Specification of national clinical audit requirements.

5. Establishing a national peer accreditation (service 'kitemarking') scheme.

6. Developing commissioning guidance packs comprising: evidence-based service specifications, exemplar service models, staffing / skill-mix guidance and dataset requirements.

7. Establishing / strengthening national and regional quality improvement networks to support local implementation of the new standards and accelerated development of new services.

8. Providing the clinical expert input required to support the development of supporting lever and incentive systems, including the mental health payment system.

NHS England will be working closely with NCCMH and with other key partners such as the HSCIC, Health Education England (HEE), Monitor, the NHS Trust Development Authority (TDA) and the Care Quality Commission to ensure effective system support and alignment.

2.7 Regional resources to support EIP implementation

As detailed in section 1.2, additional ringfenced funding has been made available to each of the regions (£200k per region) to support regional preparedness work.

Regions have been advised that preparedness work should comprise the following key elements:

1. Raising awareness of the requirements of the new standard.

2. Bringing together local experts and establishing quality improvement networks, ensuring effective linkage with strategic clinical networks.

3. Understanding levels of demand in constituent CCGs and any inequities in access relative to the levels and patterns of psychosis incidence in the population.

4. Understanding baseline performance and undertaking a gap analysis.

5. Optimising referral to treatment pathways, engaging all of the likely referral sources.

6. Preparing for the new data collection requirements and providing training for EIP service and information leads.

7. Supporting local workforce development programmes.

Rapidly establishing local levels of demand, current levels of performance against the new standard and establishing the 'gap' in terms of staffing, skill mix and training needs for each CCG area will be critical. One of the key implementation challenges is likely to be workforce development – ensuring that sufficient numbers of staff with appropriate skills have been appropriately trained to deliver the therapeutic interventions recommended in NICE guidelines CG155 (2013), CG178 (2014) and the NICE guideline for psychosis with co-existing substance misuse.
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3 Improving access to psychological therapies (IAPT)

3.1 The access and waiting time standard

The new waiting time standard requires that 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. The standard applies to adults.

Services will continue to be required to maintain the access standard of ensuring that at least 15% of adults with relevant disorders will have timely access to IAPT services with a recovery rate of 50%.

3.2 Why set a standard?

Approximately 25% percent of the adult population in England will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time, with depression and anxiety the most common.[10] Depression and anxiety disorders are serious and debilitating conditions and have significant impacts on the quality of life for individuals and their families and wider economic costs. The relevant NICE guidelines state that people diagnosed with these conditions should be offered evidence-based talking therapies as an effective treatment; this is also a service that most people with these problems want.[11]

The IAPT programme supports NHS commissioners in delivering:

- NICE approved, evidence-based psychological therapies for people with depression and anxiety disorders[12];
- Equitable access to services and treatments for people experiencing depression and anxiety from all communities within the local population;
- Increased health and well-being, with at least 50% of those completing treatment moving to recovery and most experiencing a meaningful improvement in their condition;
- Patient choice[13], and a high level of satisfaction from both people using services and their carers;

[10] www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

[11] See for example McHugh et al. (2013), Chilvers et al. (2001), Deacon and Abramowitz (2005) and van Schaik et al. (2004).

[12] Including cognitive behavioural therapy, inter personal therapy, behavioural activation, behavioural couples therapy or, if these therapeutic options are declined, counselling or short-term psychodynamic treatment may be considered.

[13] In mental health, as in physical health, legal rights to choice of provider apply when people are referred by their GP. However, people may access IAPT services via self-referral or other locally agreed referral processes. In these instances, people's choices will be determined by commissioners' local choice offers. See: NHS England, 2014, 'Choice in mental health care: Guidance on

- Improved employment, benefit, and social inclusion status including help for people to retain employment, return to work, improve their vocational situation and participate in the activities of daily living.

3.3 How will the standard be measured?

The new national indicators will measure waiting times from referral date to the start of a course of treatment – i.e. for those people who have two or more treatment sessions. Local areas will also be required to capture and monitor waits from referral to first treatment appointment for all people who enter the service and this should include people who receive a single treatment session.

Patient-initiated delays will not be taken into consideration when calculating the IAPT indicator. Tolerances have been built into the IAPT standard to allow for such delays.

A number of additional measures will be captured in national reports to guard against the introduction of perverse incentives into local commissioning arrangements by:

- Giving a larger proportion of patients a single session of assessment and advice, rather than a course of therapy;
- Reducing the average number of sessions that are given to people who need to have a course of therapy;
- Employing artificial treatment starts where patients have an early appointment but are then put on an 'internal' waiting list before a full course of treatment starts; or
- Introducing long waits into pathways where patients are 'stepped up' to a higher intensity treatment package.

Technical indicator definitions can be found in the *Forward view into action 2015/16* and frequently asked questions (FAQs) can be accessed via the Unify system. Further supporting guidance will be issued shortly.

3.4 Data collection approach

The IAPT dataset contains the fields required to measure performance against the new standards. All patient activity should continue to be recorded routinely using local IT systems. The IAPT data standard was mandated for central collection from 2011 and requires all IAPT services to submit a monthly extract of activity to the HSCIC for secondary uses (current version 1.5)[14].

implementing patients; legal right to choose the provider and team for their mental health care', available at: www.england.nhs.uk/ourwork/qual-clin-lead/pe/bp/guidance

[14] http://www.hscic.gov.uk/iapt

Indicators will be published at national, provider and CCG level on the HSCIC website.

3.5 Expectations of commissioners

The planning guidance for 15/16, *Forward view into action 2015/16* [15] requires that commissioners should agree plans with providers setting how they will prepare for and implement the new standards during 2015/16 and achieve these on an ongoing basis from 1 April 2016.

- Commissioners will need to agree service development and improvement plans (SDIPs) as part of their 15/16 contract.

- CCGs will be also be required to submit plans setting out how they will meet the new waiting time standards. These will be monitored throughout the year and compliance will be assessed in the final quarter of 2015/16.

The supplementary planning guidance highlights the importance of meeting legal duties with regard to equality and health inequalities; this should be reflected in the development of local plans.

3.6 National resources to support implementation

This will be run in two phases, supported by the £10m funding being made available in 15/16 (see section 1.2).

Phase 1 - Clearing the backlog

Using the implementation fund of £10m there are two discrete areas of investment planned for 2015/16. Allocation of funds to these two areas is still to be determined:

1. Waiting list validation i.e. activity to confirm the accuracy of current waiting lists.

2. Additional / enhanced capacity i.e. in order to provide assessments / treatments.

Allocation of the above will require careful design and a reasonably flexible approach i.e. to target areas with high waits but not reward inefficiency or low investment. Therefore it is anticipated that:

- The waiting list validation fund will be available to all CCGs but allocated to reflect capitation, scale of waits and bundled to CSUs where appropriate.
- Capacity allocation will be made according to a clear set of criteria associated with demonstrating that the issues that have led to the waiting list occurring in the first place have been identified and the additional capacity allocation will move services towards a sustainable long term solution.

[15] http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

Phase 2 - Maintaining the standard

The process of assessing the above will provide additional insight into whether problems within a given health economy are due to genuine capacity shortfalls, productivity or most likely a combination of the two. This insight will enable a clearer approach to identifying the problems and supporting local health economies accordingly.

Modelling work is in hand and this will be shared with regional and sub-regional teams over the next few months and validated against the outcome of phase 1.

Although the work programme to finalise project design of the two phases is still under development, the high level milestones that are emerging are as follows:

- **May 2015** - Identify all CCGs with long waits and offer funds, facilitation and guidance to validate waiting lists.
- **July 2015** - Identify core issues that have given rise to waiting list growth e.g. capacity, productivity or both - agree plans to rectify and allocate funds to make progress towards sustainable solutions.
- **March 2016** - Monitor and support implementation.

4 Liaison psychiatry

4.1 The access standard

Achieving better access to mental health services by 2020 set the expectation that, by 2020, all acute trusts will have in place liaison psychiatry services for all ages appropriate to the size, acuity and specialty of the hospital. NHS England is supporting this aim by targeting £30m investment in 2015/16 to enable a greater number of acute hospitals to establish effective models of liaison psychiatry. It should be noted that, from 15/16, when the Care Quality Commission (CQC) rates acute services, it will include a specific focus on liaison mental health services and mental health care, as well as the quality of treatment and care for physical conditions.

4.2 Why set a standard?

Acute hospital liaison psychiatry (often termed 'liaison mental health') teams provide services across the age-range for people:

- In acute settings (inpatient or outpatient) who have, or are at risk of, mental ill health;
- Presenting at A&E with urgent mental health care needs (particularly relating to: self harm, dementia, mood disorders, alcohol abuse, psychosis relapse and co-occurring mental health and physical health conditions);
- Being treated in acute settings with co-morbid physical health conditions and mental ill health;
- Being treated in acute hospital settings for physical conditions caused by alcohol or substance misuse;
- Whose physical health care is causing mental health difficulties;
- In acute settings with medically unexplained symptoms (MUS).

Liaison mental health services are multidisciplinary, typically comprising psychiatry, psychology, nursing and specialist substance misuse roles. They aim to increase the detection, recognition and early treatment of impaired mental wellbeing and mental ill health to improve outcomes and:

- Reduce premature mortality associated with co-morbid mental and physical health conditions;
- Reduce excess lengths of stay in acute settings associated with co-morbid mental and physical health conditions;

- Reduce risk of harm to the individual and others in the acute hospital through adequate risk assessment and management;

- Ensure that care is delivered in the least restrictive and best coordinated manner possible.[16]

There is strong evidence that some liaison mental health service models – e.g. the 24/7 RAID (rapid, assessment, interface and discharge) model can deliver better outcomes, better patient experience and more cost-effective care to patients in general hospitals with a range of mental health problems. The Centre for Mental Health report, *Liaison Psychiatry in the Modern NHS*[17], suggests that liaison mental health services could save an average hospital £5 million per annum by reducing the number and length of admissions to beds.

4.3 How will the standard be measured?

During 2015/16 NHS England will be assessing progress against the 2020 aim by commissioning a baseline and 12-month follow-up survey of liaison mental health service staffing and skill-mix in each acute hospital and a supporting analysis of service adequacy relative to the size, acuity and specialty of each acute hospital.

Whilst a waiting time standard has not been set for liaison mental health services, we are also working with the HSCIC to develop the MHLDDS so that, from April 16, it will better support data capture and analysis of referral-to-response times, referral sources and discharge destinations. Due regard will be paid to the importance of ensuring effective monitoring of any inequities in access.

NHS England is exploring the potential for gaining additional data and insight through the national clinical audit programme and we shall be seeking routinely to embed mental health in the 'physical health' audit programmes going forward.

4.4 Data collection approach

See section 4.3 above.

4.5 Expectations of commissioners

The planning guidance for 15/16, *Forward view into action 2015/16* requires that commissioners agree service development and improvement plans (SDIPs) with acute providers, setting out how providers will ensure there are adequate and effective levels of liaison psychiatry services across acute settings. The supplementary planning guidance made clear the expectation that all acute trusts should, by 2020, have in place effective models of liaison psychiatry (all ages, appropriate to the size, acuity and specialty of the hospital).

[16] http://www.rcpsych.ac.uk/pdf/JCP-MH%20liaison%20%28march%202012%29.pdf
[17] http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf

The supplementary planning guidance also highlights the importance of meeting legal duties with regard to equality and health inequalities; this should be reflected in the development of local plans.

4.6 National resources to support implementation

The National Collaborating Centre for Mental Health (NCCMH) has been commissioned to develop national resources to support implementation. Its programme will comprise the same key elements as for the early intervention in psychosis programme (see section 2.6).

NHS England will also be exploring, with the support of the Liaison Mental Health Expert Reference Group, how liaison mental health services might be incorporated within the developing urgent and emergency care payment model and within payment systems for physical health conditions more generally.

5 Eating disorders

5.1 The access and waiting time standard

This will be developed during 15/16 for introduction in 2016.

5.2 Why set a standard?

More than 1.6 million people in the UK are estimated to be directly affected by eating disorders (ED)[18]. Anorexia nervosa has the highest mortality amongst psychiatric disorders[19]. The CAMHS Tier 4 review (May 2014) noted that ED was the largest category of subspecialist beds[20].

NICE (2004) recommends:

- That most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders.

- Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

Research shows that areas with specialist community CAMHS Eating Disorder services:

- Better identify ED in primary care;[21]

- Have lower rates of admissions with non-specialist CAMHS admitting more than 2.5 times as many people;

- Demonstrate significantly lower relapse rates (5-10%) for children and young people who have responded well to outpatient family therapy than those following inpatient care[22] and there is some evidence that long-term admissions may have a negative impact on outcomes[23]; and

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[18] Treasure, J et al 2001 ‘The experience of caregiving for severe mental illness: a comparison between anorexia nervosa and psychosis.’ Soc Psychiatry Epidemioly 2001; 36(7):343-347.
[19] Herzog Nielsen S, et al, 1998 Long-term mortality in anorexia nervosa: a report after an 8-year follow-up and a review of the most recent literature, European Journal of Clinical Nutrition (2007) 61, 119–122.
[20] Of 1264 CAMHS bed commissioned, 232 were ED beds, with long length of stay.
[21] House et al 2012 ‘Comparison of specialist and non specialist care pathways for adolescents with anorexia nervosa and related eating disorders’. International Journal of Eating Disorders, 45 (8), 949 – 956, 2012.
[22] Lock et al’ Predictors of dropout and remission in family therapy for adolescent anorexia nervosa in a randomized clinical trial’. Int J Eat Disord. 2006 Dec;39(8).
[23] Gowers, S.G., & Bryant-Waugh, R. (2004). Management of child and adolescent eating disorders: The current evidence base and future directions. Journal of Child Psychology andPsychiatry, 45, 63–83.

- Are more cost effective over the 2-year follow-up (mean total cost £26 738) than in-patient (£34 531) and general out-patient treatment (£40 794).[24]

The Royal College of Psychiatrists' has undertaken three separate surveys of ED service provision in the UK, in 1992, 2000, 2012[25], each of which has identified a poor geographic availability of specialist community and inpatient ED services. The high level aims of the new standard and accompanying programme are therefore to ensure that:

- Children, young people and their families understand how to ask for help in their local areas;
- All those working with children and young people with mental health problems will know how to recognise eating disorders and how to access appropriate care when needed;
- Every child or young person with an eating disorder will get appropriate evidence based specialist treatment, based on their needs;
- There are clearly articulated agreed access and treatment waiting times standards;
- Treatment interventions are delivered by a well trained workforce;
- There are improved outcomes for children and young people with eating disorders
- The additional funding is used to deliver appropriate models of care and improve capacity across wider CAMHS Tiers 3 and 4 and to enable NHS England to plan the distribution of resources rationally;
- The delivery of collaborative commissioning models is supported; and
- The transformation of CAMHS begun by the Children and Young People's Improving Access to Psychological Therapies Programme (CYP IAPT) is continued so that services become more evidence based and outcome focussed, working collaboratively with children, young people and families to meet their needs.

5.3 How will the standard be measured?

The standard definition will be developed as part of the 2015/16 work programme.

[24] Byford S, et al (2007) Economic evaluation of a randomised controlled trial for anorexia nervosa in adolescents. British Journal of Psychiatry, 191, 436–40.
[25] Royal College of Psychiatrists'(2012) CR170. Eating Disorders in the UK: Service Distribution, Service Development and Training.

5.4 Data collection approach

This will be developed as part of the 2015/16 work programme and will be via the CAMHS Minimum Dataset.

5.5 Expectations of commissioners and providers

The methodology for distributing the funds is in development and is likely to require competitive applications by CCGs working together in appropriate clusters, with providers, to demonstrate;

- Commitment to collaborative commissioning across CCGs and to working with NHS England specialised commissioning in sub-regional teams, probably through a lead commissioning process with neighbouring CCGs;
- An understanding of the diverse needs of the population and health inequalities, in respect of CAMHS and community ED services;
- A clear understanding of what ED services are currently commissioned both locally and by neighbouring CCGs that will be party to the lead commissioning arrangement; and
- A record of working with providers, children, young people and families on service re-design, based on evidence-based practice and including partners in local authorities, education and the third sector.

Although the funds will be available to CCGs who are not yet part of the CYP IAPT programme, the application will include the requirement to demonstrate local planning to deliver outcome focussed, evidence based services in partnership with children, young people and families.

5.6 National resources to support implementation

The ED development programme will be delivered within the framework of the overall CAMHS transformation programme begun by the CYP IAPT programme. CYP IAPT is moving existing CAMHS across all agencies to become more evidence based, outcomes focussed and include strong user participation.

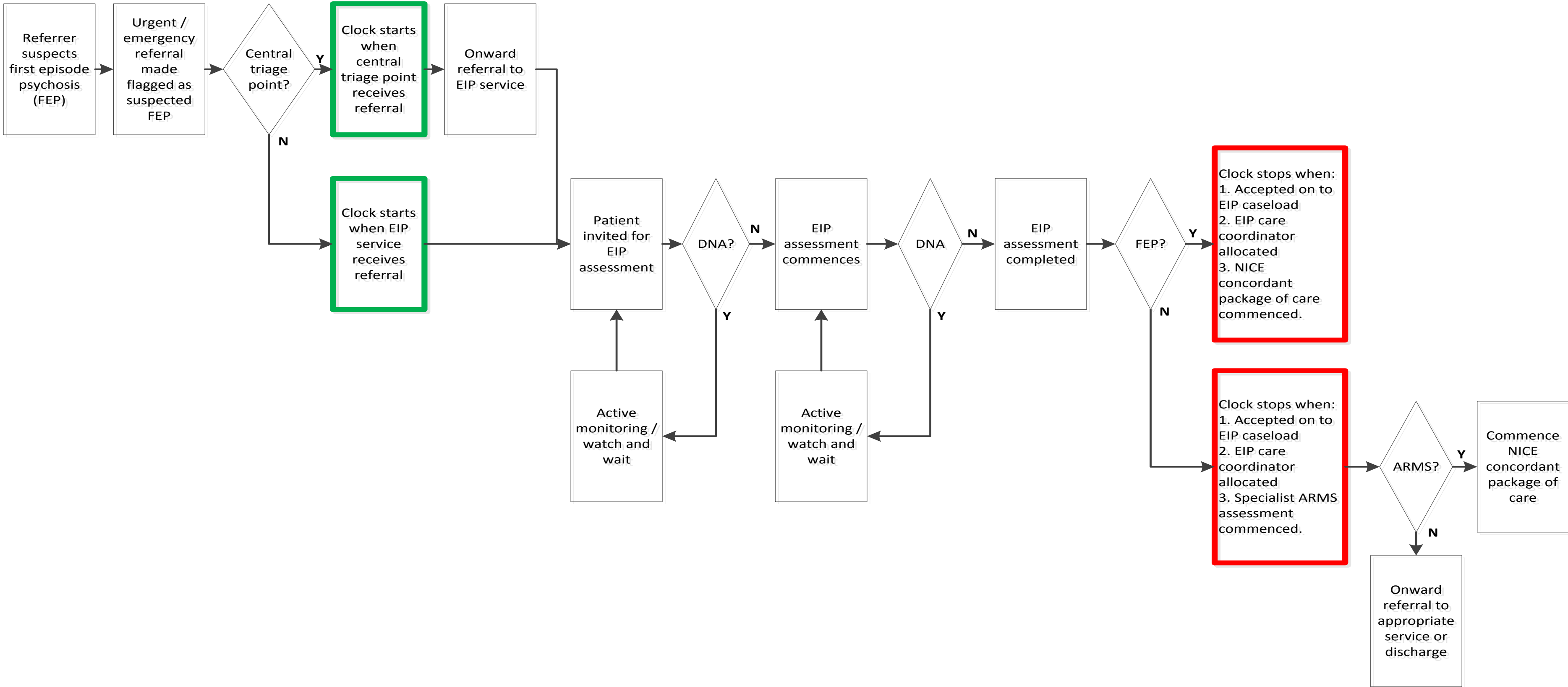
NHS England has commissioned the National Collaborating Centre for Mental Health to set up an Eating Disorders Expert Reference Group (ERG), which will meet in early 2015. This is separate from the review NICE is undertaking to the ED guidelines published in 2004, although information and learning will be shared. The ERG will develop:

- A service model for providers and commissioners;
- The access and waiting time standard that will be put in place from 2016; and
- A specification for any necessary amendments to the CAMHS Minimum Dataset.

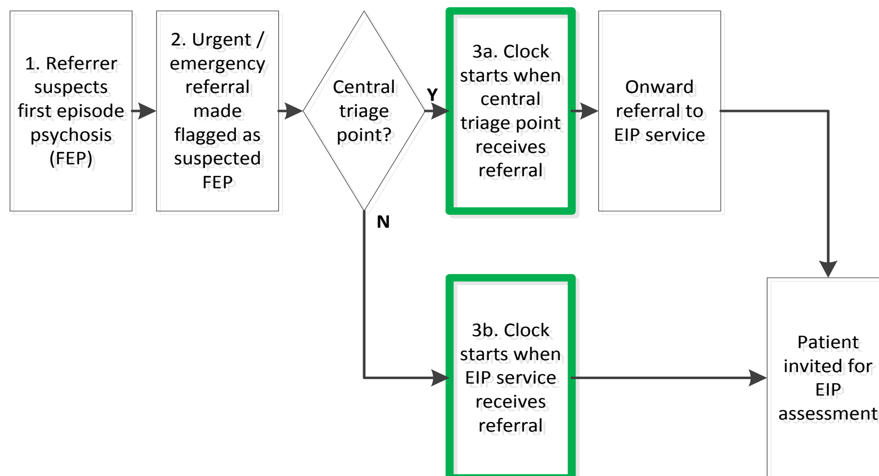
There will be support to train existing and new staff in the appropriate model of care and to assure progress, including supporting clinical network development.

Appendix 1 – Expected approach to measurement of the early intervention in psychosis 2-week referral to treatment standard

Draft referral to treatment time (RTT) pathway



Stage 1: Referral to clock start



1. Referrals for suspected first episode psychosis (FEP) will fall within two main categories:

- **Internal:** those originating from a team or ward that is within the same organisation e.g. from a crisis resolution home treatment team

- **External:** referrals from external sources including referrals from the individual, family, education, third sector agencies, GPs, justice system etc.

2. Regardless of source, the referral should be marked as '**urgent**' or '**emergency**' and '**suspected first episode psychosis**'. This action will route the referral on to the EIP RTT pathway. This rule will apply equally to people already receiving secondary care – e.g. if a person has been accepted by a Crisis Resolution/Home Treatment Team (CRHT) or admitted to an acute ward and is suspected of experiencing a FEP, the CRHT or inpatient ward will have a duty to refer the person to the EIP service with the referral clearly flagged as 'suspected FEP'.

3. The RTT clock will start on the date that the secondary care provider first receives notice of a referral from any external or internal source which has a statement indicating that the referrer suspects a FEP. Where there are self-referral pathways agreed locally by commissioners and providers, the RTT clock will start upon receipt by the secondary mental health provider organisation of the enquiry from the person or carer regarding a concern of actual or developing FEP.

   The clock will start regardless of referral source, the age of the person being referred or co-morbidities such as learning disabilities or autism. Individuals who present with substance misuse should be assessed and provided treatment by EIP services collaborating with substance misuse specialist services in keeping with the NICE guidelines for Psychosis with co-existing substance misuse.

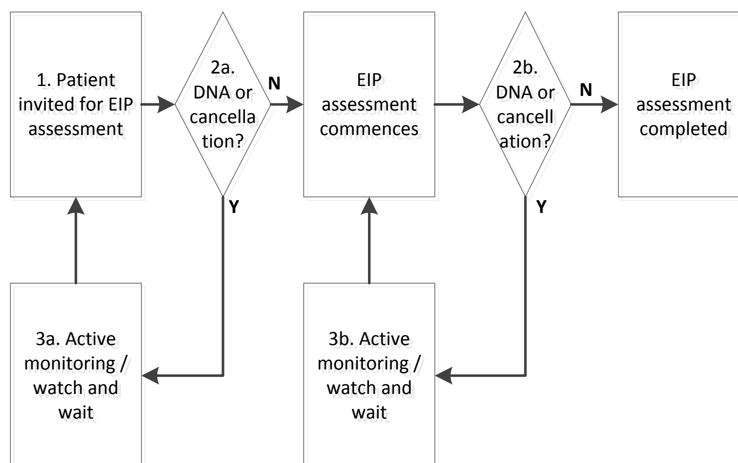
The only suspected cases of FEP exempt from these arrangements will be referrals of individuals who are experiencing psychotic symptoms in the context of organic illness such as dementia.

a. Many organisations operate a central triage point – a single telephone number or referral point to which referrers send all referrals for mental health and social care assessment for triage. These are often referred to as a Single Point of Access (SPA), Central Point of Entry (CPE) or Assessment Centre. Receipt of a referral flagged as 'suspected FEP' by a central triage point will start the RTT clock.

If the central triage point identifies a referral that would appear to be for suspected FEP but is not flagged as such, the triage function should flag the referral as suspected FEP and start the clock upon the date of receipt and then urgently refer on to the EIP service.

b. Where referrals are made directly to the EIP service (from any internal or external source), the RTT clock starts on the date the referral is received.

Stage 2: Assessment



1. Following receipt of referral by the EIP service, the person or/and their chosen accompanying support should be offered an appointment, where reasonably possible, at their convenient time and venue according to engagement and disengagement best practice guidelines.

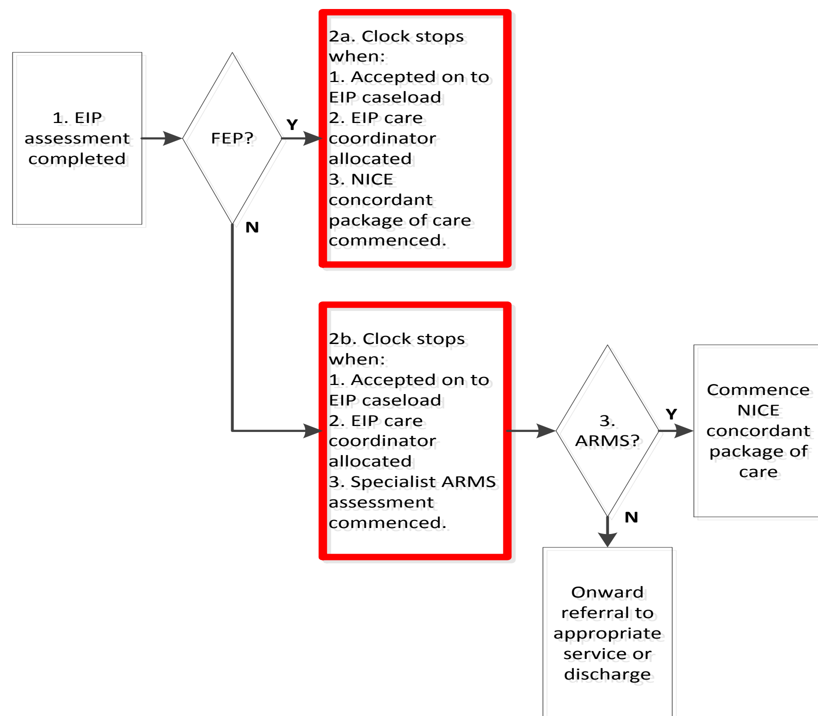
2. DNAs or patient cancellations as illustrated in steps 2a and 2b in the pathway diagram above do not stop or 'pause' the RTT clock.

3. Active monitoring / watch and wait should be initiated where the person with suspected FEP does not attend one or more of their assessment appointments and does not engage with the EIP service. An EIP team clinician should be allocated to coordinate efforts to engage the person and their support network to access psycho-education, support; and where appropriate carer support and

family interventions. The EIP clinician should continue to try to engage the person suspected of having FEP and try to engage their support network for a period of up to 6 months, whilst closely monitoring for any change in status. The EIP service should make an explicit record of all attempts of engagement and regular reviews.

The discharge of someone who has been referred as suspected of having a FEP, who the team is unable to assess, must follow engagement and disengagement best practice guidelines.

Stage 3: Assessment to clock stop



1. Completion of the EIP assessment will result in one of two decisions:

    a. The person is experiencing first episode psychosis

    b. The person may have an ‘at risk mental state’ (ARMS) – i.e. he / she is not clearly experiencing frank psychotic symptoms, but there are indicators of deteriorating mental state and functioning

2. The RTT clock stops at the start of first definitive treatment. The clock will stop for group:

    a. **Experiencing first episode psychosis** – when the person has been accepted on to caseload, an EIP care coordinator allocated and a NICE concordant package of care commenced. **All of these conditions must have been met.**

    b. **Possible at risk mental state (ARMS)** - when the person has been accepted on to caseload, an EIP care coordinator allocated and a specialist ARMS assessment commenced by an appropriately qualified EIP clinician. **All of these conditions must have been met.**

    N.B. If the person enters an acute pathway (mental or physical health) before all of the conditions of steps 2a or 2b in the pathway have been met, then the RTT clock does not stop.

3. Research has established that the emergence of psychosis is often gradual with subtle symptoms preceding frank and florid psychotic symptoms. There is evidence to show that many people with prodromal symptoms may be inappropriately discharged due to lack of specialist assessment of ARMS. EIP services should undertake a specialist ARMS assessment of anyone who is assessed and deemed not to have the nature, severity or frequency of frank psychotic symptoms to warrant a diagnosis of first episode of psychosis. This specialist ARMS assessment will ensure that people with ARMS are identified, assessed and adequately treated if appropriate, and that any transition to first episode psychosis is detected quickly. All individuals identified as having ARMS should be offered a NICE concordant package of care. NICE recommend that this prodromal group should not be prescribed antipsychotic medication.