Briefing June 2015

Commissioning for crisis care and recovery

Two areas are currently a priority in mental health: crisis care and recovery. In many ways they are linked to each other. Crisis care allows people with a mental health condition and professionals the confidence to progress to increasing self-care. Recovery helps to maximise the chances of the success of self-care. In April 2015, the Mental Health Commissioners Network met to consider the next steps for commissioning crisis care and recovery services. Over 60 people attended, most of them CCG managers and clinicians, and they heard from national leads, local innovators and service users.

"If you commission effective crisis care we can start to understand the underlying causes of crises, whether it's gangs, debt, or homelessness or other issues. Without that understanding it is really hard to think about prevention and to manage the demand."

Geraldine Strathdee, National Clinical Lead Director for Mental Health, NHS England

"Recovery means recovery of a life. It is not about recovering from an illness and simply getting rid of symptoms but about recovering a new, decent and valued life. It is about supporting people to believe that they will get better and it has a cyclical impact."

Dr Julie Repper, ImROC Programme Director

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

Introduction

As chair of the Mental Health Commissioner Network, I was keen to bring together CCGs and other key stakeholders to discuss crisis care and recovery, which are two priority areas in mental health. In April 2015, over 60 people came together to discuss and share learning and look at the next steps for commissioning these crucial services. The meeting came just ahead of a general election in which mental health was mentioned in every mainstream party's manifesto. The **Crisis Care Concordat Map** was 99 per cent green, where local area groups comprising 22 local partners from health, local government, education, the police, criminal justice and voluntary groups had approved action plans in four main areas:

- access to support before a crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously
- urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency
- quality of treatment and care when in crisis – making sure that people are treated with dignity and respect in a therapeutic environment
- recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

The recovery movement has increasing potential to support individuals in their communities in their path to increasing independence. The involvement of others with lived experience has proved to be a vital ingredient of their success.

All CCGs should by now be involved in local Crisis Care Concordat work leading to service redesign across communities. In addition, the **Mental Health Taskforce**, set up to drive forward the ambitions for mental health in the Five Year Forward View, had just started gathering input to its national strategy to be published this autumn.

This meeting was called to explore the next steps and the challenges facing commissioners as services are moved out of traditional models and into new service-user and community-focused services. I hope the following briefing highlights the many useful discussions that happened across the day, and contributes to the national debate on mental health commissioning.

Dr Phil Moore
Chair of NHSCC Mental Health Commissioners Network
Vice Chair NHS Kingston CCG and GP

"There are some really creative things happening and somehow we need to get over the 'it wasn't invented here' syndrome. Commissioners need to look at what is happening elsewhere, take a deep breath and ask 'why can't our providers do it for us?' If the answer is 'we are doing it already,' then showcase it and share it."

Andy Bell, Deputy Chief Executive, Centre for Mental Health

Action points:

- Consider your local contribution to the Mental Health Taskforce's work, including examples of exemplary practice and innovation.
- Complete the taskforce's online survey at **www.surveymonkey.com/s/mh2020**

"If we do not commission and invest in and provide highly effective treatments, it just costs the country more. This is negative capital that I, as a taxpayer, do not want to see."

Geraldine Strathdee, National Clinical Lead Director for Mental Health, NHS England

The case for change

If we are to truly transform mental health and mental healthcare, we need to have clearly articulated the case for change. Who better to do this than Geraldine Strathdee, national clinical director for mental health at NHS England? She set out a powerful case for change driven by factors such as:

- new understandings in science of the interplay between genes and the environment that give rise to mental illness
- there is much evidence for what are effective treatments in mental health
- the inclusion of service users' voices in making the case for change
- the economic case for early intervention by mental health services to help people return to work and reduce demand on physical health services – there are much more data than many people believe to support change
- commitment to parity of esteem between mental and physical health.

She described the mass movement for change that includes a social movement of 250,000 leaders for action on mental health. For the first time in a generation, there is high-level political interest in mental health that has led to the creation of a substantial body of new policy and £1.4 billion additional funding from central government.

The next step is redesigning services that are innovative and evidence based. She argued that commissioners are vital to delivering transformation. Effective crisis intervention not only helps individuals at the point of crisis but also allows service providers to understand the causes of crises and therefore offers the potential to prevent them, she added.

"The biggest saving of all is looking at the £14 billion overlap between mental health and physical health in which people have physical health problems that are due to undiagnosed mental health problems."

Andy Bell, Deputy Chief Executive, Centre for Mental Health

Action points:

- Ensure services commissioned are evidence based where possible.
- Share good practice via existing networks such as the Mental Health Commissioners Network.
- Explore new resources due out this year, including the forthcoming Atlas of Variation which for the first time includes mental health indicators.
- Contribute to collaborative work such as the Mental Health Taskforce, the Royal College of Psychiatrist's Commission on Acute Care.

Commissioning ambitions

While it is crucial for CCGs to join the national and local conversations offered through the Mental Health Taskforce and local Crisis Care Concordat groups, it is also essential that they define their local commissioning ambitions in crisis care and recovery. These might include:

- commissioning jointly with partners such as police and housing
- children and young people's crisis recovery
- developing visionary thinking on crisis care and recovery
- commissioning for positive and proactive care to reduce restrictive interventions
- commissioning for effective integration of recovery into primary care
- exploring new and innovative services for early intervention before crisis
- developing the workforce and looking after the workforce to prevent burnout
- population-based preventive approaches such as embedding parenting skills training in schools.

Some of these were explored during the day.

Recovery on the agenda

An emerging theme in crisis care commissioning is taking a recovery-based approach. Julie Repper, programme director for **Implementing Recovery through Organisational Change** (ImROC) and Waldo Roeg, ImROC consultant and peer trainer at Central and North West London NHS Foundation Trust, described a new approach built around early intervention in a crisis followed by partnership working with patients to identify their recovery goals, sharing decision-making about how to achieve those goals and planning for interventions that will prevent another crisis. It is an approach that has, in part, emerged from Francis and Berwick and is likely to be supported in a forthcoming CQC review of crisis care.

Evidence so far suggests:

- joint care plans between service users and professionals reduce the need for compulsory admission
- personal recovery plans and wellbeing plans reduce relapse and service use
- social prescribing offered before crisis via a single point of access can reduce loneliness, improve social support, increase self-confidence and self-esteem and improve skills
- the development of Recovery Colleges (of which there are now 32) that offer training to peer supporters and mental health workers may significantly reduce demand for inpatient beds to the point where they can be safely removed from the system.

Dr Repper acknowledged that recovery as a term has negative resonance among some service users, and advised not to get too hung up on terminology but to focus instead on the principles of the approach. Commissioning services that include recovery requires everyone to think and act differently.

In a separate point, Michelle Kelly, an Expert by Experience and mental health activist in her community in the West Midlands, asked CCGs to consider how to improve complaints procedures for patients and their families. It was a point that resonated with many in the audience who said they were dealing with complaints almost on a daily basis, but found processes slow and cumbersome to the point of interfering in people receiving the care they need.

"At what point do we, as commissioners, have to start getting tough and start forcing services to take beds out? If we want to change the model of commissioning, there will have to be some brave decisions."

David Smith, Co-Chair, Mental Health Network and Director of Adult Social Services, Oxford

"Co-production and shared responsibility for my safety have been part of my own recovery and my having better control of my life has opened up opportunities I felt were closed. It has given me an element of hope and I have been able to get a better life and not relegated to the dustbin. My recovery is now an asset not just to me but to others."

Waldo Roeg, Peer Trainer

"Doing things differently is the hardest nut to crack."

Dr Julie Repper, ImROC Programme Director

Children and young people's crisis care and recovery

Children and young people's mental health crisis services are perceived to be overstretched, with ever-tightening definitions of "crisis" meaning that few now receive an intervention. Waiting times can be lengthy and interventions are being curtailed. The transition from children and young people's services to adult services remains a challenge.

Kathryn Pugh, child and adolescent mental health programme manager at NHS England's medical directorate, acknowledged the problems and outlined work by NHS England to plug the gaps.

She outlined a substantial body of work now underway to address this:

- **Royal College of Psychiatrists quality improvement work** that will support standard setting
- **national minimum dataset** that will support planning and payment, due to be introduced in January 2016
- work by NHS England on standards, tier 2 and 3 model specifications, transition specifications, modelling to understand system dynamics now underway with Central and Southern Commissioning Support Unit; work on reducing the number of children held by police under Section 136; and work to support new access and waiting time targets for CAMHS.

"It's a messy, murky world with no coherence. There is no model that everyone agrees on and although we are good at asking children and young people what they want, we are less good at delivering it."

Kathryn Pugh, Child and Adolescent Mental Health Programme Manager, NHS England Medical Directorate

Case study

Jill Raeburn, CYP IAPT Transformation Manager for Tees, Esk and Wear Valleys NHS Foundation Trust, presented a case study on setting up a new child and adolescent mental health crisis team that has driven waiting times for assessment from an average of 28 hours to an average of one hour and 38 minutes.

- The service is nurse led and although it operates from a managerial base alongside adult services, it is delivered in hospitals, GP surgeries and other locations such as schools. It operates a telephone line from 8am to 10pm and takes referrals from a wide range of sources including A&E, paediatric wards, parents, schools and self-referral.
- It has been operating since May 2014 and of 109 young people assessed in A&E, only 13 were admitted; previously all would have been admitted. These young people were then offered immediate support and wraparound care. The number of community assessments has risen.
- The team has extended its work to address gaps it identified, such as training for police and reaching out to communities and young people affected by suicide. The team is looking at collaborative care planning with young people who have had a crisis.
- A key part of the success of the service had been robust clinical supervision.
- The bid to commissioners was made on an "invest to save" model. With an initial two-year cost of £400,000, it is now estimated to be on course to save £250,000 over a full year.

For more information, contact **jill.raeburn@nhs.net**

Commissioning for positive and proactive care

A year ago, the Department of Health set out a framework for reducing restrictive interventions in psychiatric, learning disability and elderly care settings. The challenge for commissioners now is to turn the **Positive and Proactive Care** framework into reality. The CQC will be focusing its inspections on this programme in 2015/16.

Joanne McDonnell, senior nurse for mental health and learning disability at NHS England's nursing directorate, spelt out the complexities of this. Commissioners need to consider:

- different types of restrictive practices such as mechanical, physical, seclusion and chemical
- how some practices are presented as for the patient's good but may just be about restricting patients
- how recording the number of incidents rarely paints the full picture of restraint
- the role of leadership in changing practice
- board-level accountability as a lever.

Regional events for commissioners will be held over the next six months with dates to be confirmed.

"The policies are there. Commissioners can hold board level people to account on this. We need to be very clear in our expectations in order for bad practices to become unacceptable."

Joanne McDonnell, Senior Nurse for Mental Health and Learning Disability, NHS England Nursing Directorate

Joint working with police

Crisis care often involves the criminal justice system. A number of police forces have started working jointly with mental health services. It is a shift in focus from "fighting crime" to "protection", a definition that encompasses vulnerable people, including those with mental health needs. It is driven by the small number of people with mental health needs in communities who are perceived to take up a great deal of police time, and to address the mental health skills gap in the police by complementing teams with mental health workers, often nurses. There is a complementary issue of police calls to deal with episodes in acute, inpatient settings, both psychiatric and in settings such as A&E.

In Trafford, police used data to provide an evidence base for closer working with mental health services. They have worked jointly with a high-level strategic group of mental health professionals from the local mental health trust and leads from the CCG and local authority. The police have assisted mental health professionals to make simple but effective changes to improve their safety. Staff swaps have helped develop mutual understanding. Meanwhile a band 6 mental health nurse has been seconded to work in the police station. This service has been trialled and is now fully commissioned by the CCG.

Some of the lessons learned were:

- the quality of the intervention is key
- scaling up a programme across a wider geographical area and with a bigger cohort won't work, but sharing ideas and lessons will help
- this particular type of programme will most likely only work on a local scale – needs to be able to understand the needs of the local community
- without the core principles of prevention and protecting the local community it will fail
- benefits go beyond the service user and include bringing people together who wouldn't ordinarily work together, and getting greater understanding of cultures/behaviours across NHS, local authority and police
- supports and equips the police to make better decisions.

"Policemen are human – they see all human behaviour in action at the front line, and in an unsupervised way."

Jim Liggett, Divisional Superintendent, Greater Manchester Police

National mental health taskforce

Dr Phil Moore, chair of the MHCN and a member of the taskforce, led sessions to gain responses from commissioners to the taskforce's three questions. The outcomes were submitted to the taskforce and will help shape the five-year mental health strategy that is being developed.

What are the three overarching ambitions for change you want to see in the way that the NHS provides mental health support – and why?

1. The person and carer

There was consensus that this must remain the central theme of all future strategies. This approach underpins all the other priorities we may set. There were a number of phrases that were used consistently including:

a. **Person-centred** – the person needs to feel all care and plans are centred around their needs and ambitions; there may be a need to review professional standards in respect of this

b. **Personal recovery plans** were seen as central and need to be easily accessible to the person and everyone involved in their support; in fact it was strongly recommended that there be a single crisis and recovery plan across all agencies

c. **Access and coordination** – care must be more joined up between agencies; this was seen to include:

   - **a single point of access** for crisis with adequate links to 111/999; should be able to link to multiple agencies for the support of the person and carer including the voluntary sector

   - **shift care to the community** stemming the rise in compulsory admissions and increased inpatient spells

   - **exclusion criteria** are currently inappropriately used in a way that bars access to services – there is an ambition to avoid their use in the future so that access is open, quicker and earlier

d. **Carers** – there was a perception that carers' assessments are not happening as frequently as they could and we need to have a fresh focus on supporting carers

e. **Caring for staff** – there was a considerable body of opinion that the best way to achieve a focus on the person and carer was to improve the way we care for the wellbeing of mental health staff; we could also benefit from creating a wider mental health staff base by skilling up workers who are not specifically mental health qualified with basic mental health training and mental health first aid training (e.g. the approach taken with dementia providing a national commitment for CQUINs across the country; the provision of mental health first aid training to voluntary sector groups, housing association staff, and so on).

2. Parity of esteem

While there was some feeling that the widespread use of this term was tending to devalue its impact, there was strong feeling that the underlying importance was, if anything, stronger. The groups felt there were themes that would help to achieve the ambition of parity, including:

a. **Wider impact of societal attitudes** – this is beyond the ability of commissioners alone to change and needs a social movement (already underway) to profoundly alter people's views; however, a change in the way the NHS and caring organisations approach care and support, and articulate that publicly will have an influence on the changes needed

b. **What does parity of esteem mean** – we need to define what it looks like when we achieve it so we can assess the extent to which we have achieved it; suggestions included:

   - **prevention and resilience** – physical health has long had a focus here and mental health is lagging behind – there were strong views that this needs to start with parenting skills in the perinatal period, progressing into primary school and education generally; social prescribing should be used at an early stage; education about their condition and mental health is essential and focusing on return to work is vital; there was a strong conviction that work on prevention and resilience could reduce referrals into secondary care and hospitalisation

   - **funding** – there was concern whether some of the methodology for assessing funding levels were valid or used correctly (e.g. how can we verify that 20 per cent of funding is spent on mental health); in particular commissioners invest funding way beyond the big provider trusts but often this is not seen as investment in mental health – one suggestion related to the use of Health Resilience Group coding as allocating actual activity/boundaried coding then triggers funding; however, more work is needed to determine how it demonstrates improved outcomes and actual activity; the use of 'policy cells' was mooted

- **moving to outcomes for commissioning** – these must include what patients value, what clinicians value and what society values and needs to be a responsibility NHS organisations share with social services, public health, voluntary organisations and patient groups; outcomes also need to cover a broader range of parameters that relate to the engagement of the person in life rather than medical aspects (e.g. Oxfordshire starts with outcomes such as physical wellbeing and being in work, then incentivise providers to deliver these outcomes by allocating a quantity of funding and deciding who is best placed to do it and then engaging those services. One example is using occupational therapists for some tasks instead of consultant psychiatrists; this has required a leap of faith beyond statistics!); access to physical health for those with mental health issues is vital and needs to be prioritised; using outcomes is more likely to shift our models of care more quickly to transformation rather than 'tweaking'

- **targeting services** in a way that mirrors physical health pathways (e.g. diabetes, stroke) is possible (such as with self-harm) but the danger of creating barriers between pathways (silos) is ever present – we do not want to recreate the difficulties that we have battled with over dual diagnosis, for example; here we equally need to focus on outcomes

- **specific areas for focus** – the groups considered that parity would need to be reflected in ensuring that children and young people have parity of care with adults, including a focus on education, the transformation of services and improved transition to adult services; older people suffering from dementia and with challenging behaviour were identified as needing additional support for parity; the cessation of the use of cells as a place of safety would suggest parity; there was some debate around people with learning disabilities and while this is not a focus for the taskforce, all identified there is an urgent need to improve the support for the mental health needs of this group of people; finally personality disorder services were raised as needing attention.

3. Primary care

Well over 90 per cent of common mental health conditions are cared for completely in primary care. While many seem to consider there is little interest in mental health within primary care, our experience in many parts of the country is quite the contrary when education, training and support for confidence and capacity is provided along with good clinical leadership. In order to be effective in commissioning mental health in primary care we identified a number of areas to focus on, including:

a. **workforce development** – this includes education and training for GPs, nurses and practice staff but also looking at IAPT services, wellbeing practitioners, secondary care nurses, mental health workers and social workers being embedded in primary care

b. **raising standards** – we need to improve the experience that people with mental health issues have of primary care – there are many examples of excellent practice but equally poor service in some areas; poor service is not just about lack of awareness as it may also reflect a decision not to engage for other reasons (e.g. resources) – we need to create something different (e.g. seven minute model doesn't work as it does not for other long-term conditions); there may be some national work to capture and spread good practice; it is not about a simple list of people with a condition but about the care, support and interventions offered; it is also about working with specialist teams to support the person in engaging with primary care for physical and mental healthcare as a lever to improve parity of esteem

c. **resources** – funding models tend to be based on physical conditions and need real creativity to develop different models; there may be a role for enhanced services (locally commissioned services) or the provision of primary care at scale in a joint contract with mental health providers

d. **defining the activity** – there is work going on in many areas on which mental health cluster care to shift to primary care

What, specifically, would need to be different by 2020? (Considering age groups, inequalities and varying mental health needs?)

1. **Funding continually rises** in comparison with other sectors of healthcare
2. **People with mental health problems feel in control of their mental health and support** – there are lessons we can learn from palliative care; improved access for BME groups and areas of deprivation
3. **Improved access to mental healthcare** – achieving waiting standards and building on these; better and wider care in primary care; better crisis access; better access to recovery support, less use of A&E, especially substance misuse and personality disorder
4. **Much more extensive use of outcomes for commissioning** – better use of contractual levers to ensure delivery of outcomes better utilised – we need better systems of verifying the value of additional activity as opposed to simply funding it. We need to deal with the paradox of the importance of mental health, the need to transform services and the need for change versus the need to performance manage, work to strict targets and the 'no health without mental health' agenda – increased use of treatment delivered using an evidence base. Concerns were raised that guidance is needed on funding liaison psychiatric services
5. **Wider use of voluntary sector and increased use of peer support** – demonstrate that increasing mental health spend is in third sector perhaps with a minimum spend; use lived experience as a resource; much greater use of peer support as crisis support; investing in peer support as a better way to use resources; asset-based development was promoted
6. **Much wider use of personal budgets** – within the framework
7. **Continued increase of focus on mental health from the top** – Parliament, NHS England, Public Health England and so on – empowers other parts of system to focus on mental health

How would you measure this change?

1. **Funding levels** (national and local statistics)
2. **Do people feel in control of their mental health and care** and do they feel they have choice (patient feedback)?
3. **How many people have integrated crisis and recovery plans** that are accessible to all involved and are the outcomes patient initiated?
4. **Statistics on access** to mental healthcare
5. **Measures of reduction in inpatient care** and reduced use of compulsion and restraint
6. **Have outcomes improved as a result of outcome based commissioning** (e.g. is the 20-year mortality gap reducing, are more people in education and training, and so on)?
7. **Measures of change in use of voluntary sector and peer support**
8. **Measures of use and effectiveness of personal budgets**
9. **Measures of improved continuity of care**, especially transition from children and young people's services to adult services

Further sources of information

- NHS Clinical Commissioners: **www.nhscc.org**

Acknowledgements

NHSCC would like to thank Daloni Carlisle, the commissioned author of this briefing.

Share your views with us

MHCN would be keen to hear any member views on the examples and points raised in this briefing. Please contact us at **office@nhscc.org**

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, Government, Parliament and the media. We're building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.

Contact us

W: www.nhscc.org
E: office@nhscc.org
T: 020 7799 8621
@NHSCCPress

Stock code: NCC00003

www.nhscc.org