01 September 2021

NHS Providers response to NHS England and NHS Improvement's *Mental health clinically-led review of standards: models of care and measurement* consultation

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

NHS Providers welcomes the opportunity to respond to NHS England and NHS Improvement's Mental health clinically-led review of standards: models of care and measurement consultation. Our response is based on feedback from our members on the proposed new standards for mental health services specifically, as well as our broader engagement with trusts on the wider programme of work underway, the Clinically-led Review of NHS Standards (CRS), to amend and evolve access standards used within the NHS. We published a briefing before the pandemic setting out our initial thoughts on this area of work and submitted a response earlier this year to proposals put out for consultation concerning the models of care and measurement of urgent and emergency care.

The consultation period for the proposed new standards for mental health services has coincided with a time when the provider sector is facing a series of significant challenges: recovering care backlogs, supporting the workforce, responding to continuing COVID-19 pressures and implementing the NHS Long Term Plan alongside broader integration changes. As a result, we could not undertake as full an engagement process with our members as we would have hoped. As such, our response does not address areas that would have required in-depth operational and clinical input. We would welcome NHS England and NHS Improvement engaging with trusts directly, beyond the consultation period if necessary, to ensure their views on the approach recommended by the CRS across mental health services, as well as the refinement of the measures and plans for implementation are fully captured and taken into consideration.

Key points

- We support the proposals to develop new standards covering a broader range of mental health services. We know from all the clinical evidence available how important timely access to services is both to prevent mental ill health and avoid where possible conditions worsening. The introduction of these standards is also an important step towards parity of esteem by providing more information about the demand for, and access to, mental health services and a potential means to support more effective models of care delivery.
- If the NHS is resourced to meet these new standards, at thresholds on a par with those we expect for individuals seeking NHS services for physical health conditions, they will prompt a genuine improvement for patients and go some way to reducing the unacceptable care deficit in mental health, which still exists despite welcome investment and focus in recent years and the best efforts of those working in and leading the sector. The provider sector has demonstrated it can expand and transform services to improve access and quality of care when it is given the support and resources it needs to do so.
- Additional access and waiting time measures for a broader range of mental health services, and resources to enable them to be met, are more important now than ever. The full mental health impact of the pandemic is still emerging, but trust leaders are reporting extraordinary pressures. In particular, a high proportion of children and young people not previously known to services are coming forward for treatment, and they are more unwell, with more complex problems than in the past. NHS England and NHS Improvement are right to stress the importance of setting thresholds for these standards that acknowledge the task ahead for trusts to recover from the pandemic alongside the continued expansion and transformation of mental health services.
- Meeting these new standards, at thresholds we expect for those seeking NHS services for physical health conditions, will require additional funding beyond current commitments, including money for buildings and equipment, and a significant strengthening of the workforce fundamentally. Trusts will need one off resources to remove any waiting lists and then ongoing recurrent resources to enable the capacity to be introduced to meet the standards over the longer term. We estimate that, as a minimum, the mental health sector needs an additional £850m of revenue funding a year to meet current levels of demand and tackle the backlog of care caused by the pandemic. The sector also needs a minimum of £2bn to deal with the most urgent capital demands for upgrading units and building new facilities.
- It will be important to ensure the standards are accompanied by clear guidance, as well as investment, to ensure services for assessment are not prioritised at the expense of services for care and treatment, or services that remain without an access standard attached to them but need to be a focus and priority for trusts given their local contexts. Mental health trusts having

previously told us how sector investment followed the standards and we were in danger of prioritising services with standards, such as Improving Access to Psychological Therapies (IAPT) services, over provision for those with more severe and enduring mental health conditions.

- There are also significant, systemic challenges to consistently providing the right level and nature of mental health support in a timely way that need to be tackled. How mental health services and their partners in the wider system are resourced, commissioned and funded needs to be addressed to improve access and the quality of care for individuals across the country fundamentally. There must be increased support for public health and social care in particular given the crucial role these services play in providing people with the wider care and support they need and helping both to prevent mental ill health and avoid where possible conditions worsening.
- We welcome the approach taken by NHS England and NHS Improvement to date to involve trusts and other stakeholders in the design, consideration and implementation of the new standards and hope it continues. Implementation planning must be realistic and honest about what resource and time is needed to introduce these standards successfully, taking full account of the current operationally challenged context and ongoing and anticipated long-term impact of the COVID-19 pandemic on the NHS.

Consultation questions

Additional access and waiting time measures for mental health services

To what extent do you agree or disagree with the proposals for mental health services to have additional access and waiting time measures?

We agree that mental health services should have additional access and waiting time measures. We know from all the clinical evidence available how important timely access to services is both to prevent mental ill health and avoid where possible conditions worsening. The development of new standards covering a broader range of mental health services is also an important step towards parity of esteem. They will provide more information about the demand for, and access to, mental health services and a potential means to support more effective models of care.

If the NHS is resourced to meet these new standards, at thresholds on a par with those we expect for individuals seeking NHS services for physical health conditions, they will prompt a genuine improvement for patients and go some way to reducing the unacceptable care deficit in mental health, which still exists despite welcome investment and focus in recent years and the best efforts of those working in and leading the sector. The provider sector has demonstrated it can expand and

transform services to improve access and quality of care when it is given the support and resources it needs to do so.

Additional access and waiting time measures for a broader range of mental health services are more important now than ever. While the full mental health impact of the COVID-19 pandemic is still emerging, trust leaders are reporting extraordinary pressures. In particular, a high proportion of children and young people not previously known to services are coming forward, and they are more unwell, with more complex problems than in the past – as illustrated in findings from our most recent survey of mental health trust leaders. Trust leaders are also very concerned about staff wellbeing and current levels of stress and burnout across their workforce. We therefore welcome NHS England and NHS Improvement highlighting the significant and ongoing impact of COVID-19 on services in the consultation document and agree about the need to ensure setting of performance thresholds acknowledges the task ahead for trusts to recover from the pandemic alongside expanding and transforming mental health services as envisaged prior in the NHS Long Term Plan.

Meeting these new standards, at thresholds we expect for those seeking NHS services for physical health conditions, will require additional funding beyond current commitments, including money for buildings and equipment, and a significant strengthening of the workforce – through financial investment, recruitment, training and retention – fundamentally. Trusts will need one off resources to remove any waiting lists and then ongoing recurrent resources to enable the capacity to be introduced to meet the standards over the longer term. We estimate that, as a minimum, the mental health sector needs an additional £850m of revenue funding a year to meet current levels of demand and tackle the backlog of care caused by the pandemic. The sector also needs a minimum of £2bn to deal with the most urgent capital demands for upgrading units and building new facilities.

There has been a welcome focus, and some good progress made to grow the mental health workforce in recent years, but thousands more staff are needed by 2022/23 and more required beyond that to deliver longer-term ambitions for the sector as well as respond to the impact of the COVID-19 pandemic. The impact of steps trusts have been taking to meet the workforce gaps they face – by using new roles, changing skills-mixes, and pursuing a range of recruitment and retention initiatives – are limited without greater national progress on growing and funding the domestic pipeline and retention initiatives. We are still waiting for a fully costed and funded national workforce plan for the longer term that builds on the steps taken to grow the mental health workforce to date, taking into account the new context trusts are now operating in. There also remains a need for national policy makers to align their thinking across the health and social care sectors.

Investment in digital technology for the sector is also important to support the transformation required to both reflect patient need and broaden choice, and to implement the standards successfully. A broader approach needs to be taken to digital funding, with clarity provided to trusts about how they can expect to make longer term, sustainable investments in digital ways of working, that recognises both the revenue and capital implications. Trust leaders themselves will be best placed to make investment decisions. For many, this will involve investing in core infrastructure to make things easier for staff: from improving wi-fi coverage to fixing slow log in times. Trusts leaders are conscious that there are still significant barriers to overcome – including accessibility, information governance issues and the appropriateness of a digital setting for some therapeutic interventions and each patient's individual needs – and of the need to assess and evaluate the impact of delivering services digitally over the longer term.

It will be important to ensure the standards are accompanied by clear guidance, as well as investment, to ensure services for assessment are not prioritised at the expense of services for care and treatment, or services that remain without an access standard attached to them but need to be a focus and priority for trusts given their local contexts. Mental health trusts having previously told us how sector investment followed the standards and we were in danger of prioritising services with standards, such as Improving Access to Psychological Therapies (IAPT) services, over provision for those with more severe and enduring mental health conditions.

Further clarity also needs to be provided on how the targets should be managed in practice – for example when to 'start/stop the clock' for each standard, what happens to patients outside of emergency departments, and what the approach should be for those who cannot be assessed or do not wish to engage in treatment. Trust leaders have stressed the importance of standards being accompanied by clarity on definitions that are meaningful to patients in terms of what constitutes the 'start' of receiving help in particular.

We are also keen to stress that there are significant, systemic challenges to consistently providing the right level and nature of mental health support in a timely way that need to be tackled. These new standards do not cover the whole pathway from prevention through to treatment and measure success at each stage. How mental health services and their partners in the wider system are resourced, commissioned and funded needs to be addressed to improve access and the quality of care for individuals across the country fundamentally. There must be increased support for public health and social care in particular given the reductions we have seen in their budgets and the crucial role these services play in providing people with the wider care and support they need and helping both to prevent mental ill health and avoid where possible conditions worsening.

Community-based urgent mental health services (all ages)

To what extent do you agree or disagree with the proposed standards: for a 'very urgent' presentation to a community-based mental health crisis service, a patient should be seen within 4 hours from referral, across all ages; for an 'urgent' presentation to a community-based mental health crisis service, a patient should be seen within 24 hours from referral, across all ages.

We support introducing standards for community-based urgent mental health services, so that people in crisis are able to access the support they need in a timely way and in a safe setting that can provide the most appropriate care. If properly resourced, this should also help ease pressures on emergency departments.

There has been welcome investment and some good progress made in the delivery of mental health crisis and liaison services in recent years. However, more investment is needed to go further and tackle current waiting lists as well as enable the capacity to be introduced to meet these new standards over the longer term. This is particularly the case for children and young people where the crisis pathway is less well developed, and where the new context trusts are now operating in as a result of the COVID-19 pandemic has had a far reaching impact.

Trust leaders are particularly concerned about the availability of the appropriately trained staff needed to meet these two standards in practice, and have highlighted this and recruitment difficulties as key issues that must be taken into account for implementation of the new measure and when planning for additional support that might be needed.

Trusts leaders have highlighted the difficulty in defining 'urgent' and 'very urgent' and we would welcome guidance that seeks to define the two terms as clearly as possible to support the implementation of the standard. They have also highlighted the need for clarity on the expectations around clock starts and stops, which take into account the different models of provision being used across the country, to ensure consistency in measurement and comparison. Trust leaders would welcome further aspects of these two standards being clarified, such as whether a standardised triage process will be used and who (for example a mental health care professional) needs to have 'seen' the patient in order to meet each standard.

Meeting mental health needs in emergency departments (all ages)

To what extent do you agree or disagree with the proposed standards: for a referral from an emergency department, patients should have a face-to-face assessment by mental health liaison, or children and young people equivalent service commence

within 1 hour. All A&E standards as set out in the Transformation of urgent and emergency care: models of care and measurement consultation paper (December 2020) will be applicable to patients presenting with mental health needs.

We agree with the proposed standard for meeting people's mental health needs in emergency departments. Many of our members have flagged their ongoing concerns for mental health patients and service users, and the need for standards to support the delivery of timely, appropriate care for those with mental health conditions presenting to emergency departments.

Trust leaders have highlighted how difficult it can be to evidence the pressures facing emergency departments in terms of the number, complexity, and acuity of mental health patients presenting. We know, for example, that a large proportion of current 12-hour breaches in emergency departments are mental health patients waiting for a bed in a more appropriate service. If the standard drives the right responses and is resourced properly, it should help to better meet patients' needs presenting to emergency departments and enable them to receive the most appropriate care as soon as possible.

Some trusts have told us it would be helpful for a differentiation to be made in the standard for patients who may require medical interventions first and mental health interventions later. It will also be important for guidance on the final standards to provide clarity around 'clock starts and stops' – for example what constitutes a full 'assessment' – to ensure people's needs are truly being met through the achievement of these targets.

We note in the consultation document that "services will be encouraged to focus on accurately recording and reducing the steps following the face-to-face consultation, particularly where a decision to admit the patient has been made and reducing the time to admission". Trust leaders have highlighted that liaison psychiatry assessment is only a starting point for many patients and there needs to be sufficient investment in capacity in other mental health services to meet patients' needs in a timely way following an initial assessment. There also needs to be adequate investment in the capacity of other mental health services, and effective promotion to the public of their existence and effectiveness and how they can be accessed, to mitigate the risk of this standard cementing A&E as the preferred access route for patients with mental health needs, when their needs could be better met by other services than liaison psychiatry.

A key issue that must be taken into account for implementation is the space and facilities required within A&E departments for adult and children and young people (CYP) liaison services. There needs to be an appropriate number of dedicated spaces in or near all emergency departments where individuals in mental crisis can be assessed privately and with dignity. For many areas of the country,

this will require capital investment. Capital investment in emergency departments to make them a more therapeutic environment for all, whether they have a physical or mental health need, would enable better outcomes for patients and staff experience more broadly.

The importance of adequate and safe staffing levels in emergency departments for successful implementation of this standard cannot be understated, particularly for CYP services where there are some of the most significant workforce shortages. It is important that 24-hour mental health liaison and the CYP equivalent are both present, trained properly and have the right support in place so they can feature as part of early assessment in every emergency department and best help individuals presenting with urgent mental health conditions. Robust training and support also needs to be provided to help clinical teams across the urgent and emergency care pathway understand psychosis, and to care for those who have self-harmed or have attempted suicide.

We note the consultation document states that "to support these measures, additional contextual indicators will be used to understand operational pressures and improvement points including the urgent and emergency care bundle of measures applied to all emergency department presentations, and specific mental health metrics included in other published reports". We would welcome NHS England and NHS Improvement setting out such contextual indicators and mental health metrics that will be used in detail in the final guidance on the standards so this is completely clear to trusts.

Non-urgent community-based mental health services for children and young people

To what extent do you agree or disagree with the proposed standards: Children, young people and their families/carers presenting to community-based mental health services, should start to receive help within four weeks from request for service (referral). This may involve immediate advice, support or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment that may take longer.

We agree with the introduction of standards for children and young people to access non-urgent community based mental health services. More rapid intervention will improve individuals' outcomes and limit the deterioration of a child or young person's condition while waiting in the cases where a longer-term intervention or care plan is required.

We are pleased to see the standard acknowledge that specialist assessment may take longer. Findings from our recent member survey laid bare the current pressures facing services despite trusts efforts to

expand services and provide the best possible care with the staff and resources available: two thirds of trust leaders who responded to the survey said they were not able to meet demand for community and inpatient services for children and young people, and 78% were concerned about their trust or local system's ability to meet the level of anticipated demand for these services in future.

Some areas working as part of the four week waiting time pilot had to pause this work when it was not operationally viable at the peak of COVID-19 first wave pressures. We therefore welcome that piloting of this standard has been extended to the end of 2021/22 to allow for further testing and refining of the standard, the development of an implementation plan and setting of future performance thresholds, as well as the package of measures to understand the impact of this programme. We hope that this extended period will also be used for the timely dissemination of key learnings, on what has not worked and why as much as what has, from pilot sites to the rest of the sector to support successful wider roll out and implementation.

We know pilot sites have come up against a number of challenges which will be important to keep front of mind as piloting and planning for implementation and setting performance thresholds continues this year. These include: workforce capacity, measuring activity and outcomes, identifying and managing internal waits, and ensuring ease of access and re-entry for children and young people to services. The digital capability of mental health trusts has been a further key challenge highlighted by trust leaders. Due to the nature of the referral-based approach, and timescales in the proposed standards, there is work to do locally between primary and secondary care providers around information sharing and data governance, and the time and resource implications also need to be considered.

It will be important to confirm as soon as possible when and to what extent NHS England and NHS Improvement intend to start to implement these standards across the country. Trust leaders have told us there will need to be sufficient time allowed to move from current waiting times to these new standards. Recruitment and retention of staff in children and young people's community services has been highlighted as particularly difficult and meeting the standard with the current access criteria used by commissioners and providers will require significant additional staffing and associated funding beyond the current mental health investment standard. Without the right resources, there is a risk of creating longer hidden waits for subsequent treatment in the cases where the initial 'help' – the focus of the standard – does not fully address a patient's needs.

Similarly to the other standards, trust leaders are clear about the importance of having clarity around 'clock starts and stops' across all providers so that measuring is consistent and comparable.

Non-urgent community-based mental health services for adults and older adults

To what extent do you agree or disagree with the proposed standards: For non-urgent, community mental health care Adults and older adults presenting to community-based mental health services should start to receive help within four weeks from request for service (referral). This may involve the start of a therapeutic or social intervention, or agreement about a patient care plan.

We agree with the introduction of standards for adults and older adults to access non-urgent community based mental health services for the same reasons we have outlined regarding the standard for children and young people requiring non-urgent mental health services: to improve outcomes and prevent people's conditions from worsening unnecessarily.

As with the standard for children and young people, trust leaders are clear that will need to be investment in services and sufficient time allowed to move from current waiting times to these new standards. We do recognise that there is a welcome, significant programme of work underway, with dedicated funding from the NHS Long Term Plan, focused on community mental health services for adults and older adults that will help to build the workforce and transforming models of care to meet the standard, but we know this will take time to fully deliver. Indeed, roll out of the programme across the country only began from April of this year, and we also know the two year early implementer phase of the programme was impacted by the pandemic. 85% of mental health trust leaders we surveyed before this programme began did not feel there were adequate mental health community services to meet local needs, which highlights the scale of the challenge this programme is focused on addressing.

We are also mindful that the funding and workforce trajectories agreed for this programme beyond this year were set prior to the pandemic, and so calibrated to address a treatment gap due to a lack of investment in core community mental health services historically and not the impact COVID-19 has, and is expected to continue to have for some time to come, on levels and the acuity of demand for mental health services. We estimate that, as a minimum, the mental heath sector needs an additional £850m of revenue funding a year to meet current levels of demand and tackle the backlog of care caused by the pandemic across all services. The sector also needs a minimum of £2bn to deal with the most urgent capital demands for upgrading units and building new facilities.

As with the standard for children and young people's access to non-urgent care in the community, key issues that need to be thought through ahead of implementation that trust leaders have identified include recruitment and retention and the risk of creating longer hidden waits.

Trust leaders have highlighted that this standard has the potential to be one of the most difficult to define consistently as it will apply across such a large number of different services and pathways. The work being undertaken to transform models of community mental health care for adults and older adults may create more diverse and less well-defined pathways, which may make it more difficult to apply standard measurements. The final version of this standards needs to take the range of changes being made across the country as part of the programme fully into account, which will inevitably take time given where the sector is with roll out and implementation currently.

We note in the consultation document that the "standard will be part of a range of metrics monitored to ensure both access and quality of care is improving" and would ask that the other metrics NHS England and NHS Improvement have in mind to monitor are clearly communicated to trusts as soon as possible.

Advising and communicating the new measures to service users and families/carers

We agree with most of the suggestions put forward for advising and communicating the new standards to service users and their families and carers. The public should be able to access clear information on the different access points to NHS mental health services across a range of media, from social media to printed materials in GP surgeries. It is vital that a robust, joined-up communications strategy helps inform the public about the new standards.

NHS England and NHS Improvement need to identify what will be clearly communicated to the public when and how. It is important that service users and the public are aware of what they can expect from services: there is a risk the NHS may over promise and underdeliver if this work is not communicated at the right time and in the right way given the current mismatch between capacity and demand and longstanding care deficit and historic underinvestment in mental health more broadly.

In terms of access to data on trusts' performance against the standards, data must be clearly visible and accessible to patients and the public on hospitals' and NHS England and NHS Improvement websites.

Implementation

NHS England and NHS Improvement acknowledge that further work is needed to assess the appropriate level of expectation for each measure, before they could be implemented. There needs to be proper due diligence on what resource and time the implementation of new standards will actually take once we are clearer on the level of expectation for each measure. The standards must be presented as part of well thought through and fully co-created implementation plan that takes full account of current operational, financial and workforce pressures. Trusts will also need adequate support in implementing the standards including the right IT, right staff, right resources and training where required. Frontline staff will also require clear instructions setting out expectations and timelines.

Other overarching considerations regarding implementation of these standards include: workforce challenges, particularly viewed through the COVID-19 lens; digital and technical capacity and capability across the provider sector; and data sharing and information governance, particularly between providers and across systems. There is also an incomplete picture of how the measures will be used in any performance management and oversight framework, what the thresholds will be to drive real tangible improvements in patient care, and how the measures align with system working.

The implementation of the new measures raises significant data and IT challenges with varying degrees of change required dependent on the digital capability of each trust. Without significant financial investment and support from national bodies, it is unclear how trusts who do not currently have the EPRs or the IT systems they need will be able implement (and be held account) for delivering the new standards.

We would recommend a phased approach to implementation that allows the sector to build up the capacity required to meet the standards – in step with the increasing levels of, and more complex, demand anticipated – alongside transforming pathways in conjunction with other service priorities. We have broadly welcomed the approach taken to testing these new standards to date with pilot sites involvement in the design and consideration of the new standards. It will be important to continue to take this approach involving all providers and widely share learning across the sector to support an effective wider-roll out and implementation.

Data flows and reporting

While we do not support burdensome, and disproportionate bureaucracy, we agree that it is important that NHS activity and performance data is transparently reported to ensure the NHS is accountable to the public, regulators and the government.

We recommend reporting across all measures takes place on a monthly basis, in line with other activity and performance reporting structures, whilst ensuring that recording these measurements does not place unnecessary administrative burden on both clinical and non-clinical staff. Training on how to measure, report and record data points will be important. There must be clear and concise definitions around the new measures to ensure consistency across trusts in terms of what and how they measure.

It makes sense that data will be available to systems and services initially, rather than publicly, while focused efforts on increasing the volume and accuracy of data flowed to national data sets is undertaken. Trusts and national bodies need to prioritise working together to make further progress on data collection and data quality to give a better understanding of mental health activity, access and outcomes that can then enable better commissioning and the provision of services.

Addressing inequalities

The consultation document highlights that advancing equalities in access, experience and outcomes in mental health services is a fundamental priority for new integrated care systems (ICSs) as they develop, and the work to update and improve NHS standards must not worsen inequalities more broadly. In light of this, we would welcome further detail in the guidance that accompanies the final standards on how they have been devised with tackling health inequalities in mind. This is key to supporting trusts and their partners to maintain the clear focus that is needed, and our experience of COVID-19 pandemic has only served to reinforce, on tackling health inequalities within their local populations.

We would also welcome the final standards and accompanying guidance to more explicitly align with NHS England and NHS Improvement's Advancing mental health equalities strategy. We welcomed the strategy, and its focus on the need to identify and share positive practice so that local areas can learn from what works in a systematic and coordinated way. It is also right for NHS England and NHS Improvement to prioritise supporting local systems and improving data and information, given the need for a greater understanding within systems of the mental health and wellbeing needs of the specific communities they serve, and for services that meet these needs to be prioritised by systems accordingly.