# Improving services for people with mental health needs who present to A&E

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| **Indicator name** | Improving services for people with mental health needs who present to A&E. |
| **Indicator weighting (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | **For 2017/18:**<br>1. Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.<br><br>**For 2018/19:**<br>1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions.<br><br>2. Reduce total number of attendances to A&E by 10% for all people with primary mental health needs[1].<br><br>**Mental health and acute hospital providers,** working together and, likely also with other partners (primary care, police, ambulance, substance misuse, social care, voluntary sector), to ensure that people presenting at A&E with primary or secondary mental health and/or underlying psychosocial needs have these needs met more effectively through an improved, integrated service offer, with the result that attendances at A&E are reduced.<br><br>The CQUIN has been designed so as to encourage collaboration between providers across the care pathway and as such is to be applied to both acute providers and mental health providers. While it takes account of different responsibilities for providers, performance by both acute and mental health providers will be measured and shared across the pathway, and will affect overall achievement against the CQUIN indicator. All mental health and acute |

[1] See section below for rules on partial achievement

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| | providers subject to the scheme will therefore need to work together to ensure the successful delivery of all milestones and to achieve levels of performance necessary to release full reward.<br><br>Successful achievement of the CQUIN is therefore likely to necessitate partnership working and joint governance between CCGs, acute providers, mental health providers and other key local partners. Areas may wish to use existing forums such as A&E Delivery Boards and Urgent and Emergency Care Networks to oversee this process.<br><br>Where there are a number of providers fulfilling the acute or mental health provider role for a given locality, their contribution to overall performance for that locality should be weighted in line with their respective levels of commissioned activity for that locality. CCGs will need to determine the allocation of the rewards locally, based on their local geographies, taking into account:<br>a) the differing provider geographies (e.g. mental health providers may serve populations across the footprints of varying numbers of A&E departments);<br>b) different arrangements in different areas – for example, some liaison services are provided by mental health trusts and some are provided by acute trusts; and<br>c) the milestones set out in the CQUIN – the achievement of which are contingent on actions from either mental health providers, acute providers, or both working together; CCGs will therefore need to consider and agree with providers the proportion of the indicators for each year that will be delivered by the acute provider(s), what proportion will be delivered by the MH provider(s), and what by both.<br>Through this mechanism, the CQUIN is designed to incentivise both acute and mental health providers to contribute to improved services for people with mental health and psychosocial needs who present to A&E.<br><br>Year 1 will focus on improving understanding of the complex needs of a small cohort of people who use A&E most intensively. There will be a particular focus on identifying those people within this cohort who may benefit from integrated mental and physical health |

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| | assessment, care planning and interventions[2]. There will also be an intensive focus on improving the quality of coding of primary and secondary mental health needs in A&Es.<br><br>Year 2 will seek to maintain the progress of year 1 – or previous years where a reasonable baseline reduction has already been established – for the selected cohort of frequent attenders, but the focus will broaden to deliver a reduction in the number of attendances to A&E for all people with primary mental health needs.<br><br>*Year 1*<br>1. Identify the people who attended each A&E most frequently during 2016/17 (this is likely to be people who would usually attend A&E 10-15 times or more; the cohort will need to be adjusted for attrition[3]).<br>2. Review this group and identify the sub-cohort of people for whom mental health and psychosocial interventions led by specialist mental health staff would have the greatest impact. The number of people in the cohort will need to be agreed locally between providers and commissioners. It is expected that cohorts will include at least 10-15 people per hospital site. However, where possible, larger cohorts than this are encouraged as the greater the number of people in the cohort, the greater the potential benefits. For large hospitals serving greater populations, commissioners should seek to include larger cohorts in the scheme. Individual hospitals will have their own systems and methods of identification and this cohort's number of attendances for 2016/17 and number of patients will be recorded to set the baseline;<br>3. Review and develop a co-produced care plan[4] for each person in this cohort, which includes a |

[2] Please see 'rationale' section below for further detail about selection and segmentation of this cohort
[3] E.g. due to deaths, relocations out of area etc.
[4] The care plan may be known by other names, such as an attendance plan or personal support plan. The purpose of the plan is to guide care delivered by staff whenever an identified patient attends A&E, promoting consistency of care that aims to better meet the needs of patients. Involvement of patients and carers in their co-production is essential, and other partner agencies including primary care should be aware of the plans, and have access and contribute to their development as necessary. They should include a patient's key health and care issues and accompanying management plans, and other relevant information such as the different named professionals involved in their care.

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| | focus on preventing avoidable A&E attendances. While a collaborative approach is critical to the successful implementation of this CQUIN scheme, the appointment of a named dedicated clinical lead or leads is likely to be beneficial. Care plans should be made available to A&E departments so that when a named person in the selected cohort does attend A&E, they receive more consistent care that better meets their needs. Care plans should be developed with the individual in question and involve and/or be shared with other relevant partner organisations where appropriate, such as primary care, including as part of the discharge planning process. Consideration should be given to the use of integrated and interoperable electronic care records or the enhanced Summary Care Record as enabling platforms.<br>4. Strengthen existing / develop new services to support this cohort of people better and offer safe and more therapeutic alternatives to A&E where appropriate.<br>5. Over one year, reduce by 20% the number of attendances to A&E for those within the selected cohort of frequent attenders, and establish improved services to ensure this reduction is sustainable;<br>6. Improve the quality of A&E diagnostic coding for mental health needs (primary and secondary), ensuring that coding for the final quarter of the year is complete and accurate; ensure systems are in place to assure quality of mental health diagnostic coding in the A&E HES dataset going forward, including conducting an internal audit of all mental health diagnostic coding to provide assurance of data quality.<br><br>*Year 2*<br>1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions;<br>2. Reduce total number of attendances to A&E by10% for all people with primary mental health needs.[5] |

[5] See section below for rules on partial achievement

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| | 3. Strengthen existing / develop new services to support people with mental health needs better and offer safe and more therapeutic alternatives to A&E where appropriate.<br>4. Repeat internal audit of mental health diagnostic coding in A&E to provide assurance of the quality of coding.<br><br>The benefits expected from this CQUIN would be:<br>• Identification of the most intensive users of local emergency physical and mental health services and improved understanding of their health and care needs and joint review / creation of personalised care plans for this cohort;<br>• Reduced healthcare usage, reducing avoidable pressures on emergency departments and GP services;<br>• Improved health and social outcomes for this cohort;<br>• Improved experience of health and care services for this cohort, including reduced stigma through increased staff education and awareness;<br>• Improved data quality and recording of mental health need in emergency departments;<br>• Improved integrated care pathways across providers, including timely communication and collaboration between acute trusts, mental health providers, ambulance services, primary care, social care, public health (drug/alcohol services) and the voluntary sector; and<br>• Joint governance and working between various providers will provide a better picture of local needs and demand, which can inform commissioning. |
| Numerator / Denominator | **For Year 1 (2017/18):**<br><br>1. Reduce by 20% the number of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable: |

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| | $= \left[ \frac{\text{Number of Accident and Emergency presentations during } 2017-18 \text{ from those within the selected cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial interventions}}{\text{Number of Accident and Emergency presentations during } 2016-17 \text{ from those within the selected cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial intereventions}} \right] \times 100\%$<br><br>e.g:<br><br>$\left[\frac{150 \text{ presentations in } 2017-18}{200 \text{ presentations in } 2016-17}\right] \times 100\% = 75\% \text{ (i.e. 25\% reduction)}$<br><br>**For Year 2 (2018/19):**<br><br>1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions - the cohort will need to be adjusted for attrition[6];<br><br>$= \left[ \frac{\text{Number of Accident and Emergency presentations during } 2018-19 \text{ from those within the cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial interventions}}{\text{Number of Accident and Emergency presentations during } 2017-18 \text{ from those within the selected cohort of frequent attenders in } 2016-17 \text{ who would benefit from mental health and psychosocial intereventions (}\textbf{cohort to be adjusted for attrition}\text{)}} \right] = \leq 1$<br><br>2. Reduce total number of attendances to A&E by 10% for all people with primary mental health needs[7]; |

[6] E.g. due to deaths, relocations out of area etc.
[7] See section below for rules on partial achievement

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| | $= \left[ \frac{\text{Total Number ofAccident and Emergency presentations of people with primary mental health diagnosis during Q4 } 2018-19}{\text{Total Number ofAccident and Emergency presentations of people with primary mental health diagnosis during Q4 } 2017-18} \right] \times 100\%$<br><br>e.g:<br><br>$\left[ \frac{1275 \text{ presentations in Q4 } 18-19}{1500 \text{ presentations in Q4 } 17-18} \right] \times 100\% = 85\% \text{ (15\% reduction)}$ |
| **Rationale for inclusion** | People with mental ill health are 3 times more likely to present to A&E than the general population. More than 1 million presentations are currently recorded as being directly related to mental ill health. People with known mental ill health are 5 times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical health reasons . This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.<br><br>The QualityWatch study also found that people with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14, and that "the high levels of emergency care use by people with mental ill health indicate that they are not having their care well managed and suggest that there are opportunities for planned care (inside and outside of the hospital) to do more. These people are well known to the healthcare system and are having many health encounters".<br><br>Source: http://www.qualitywatch.org.uk/focus-on/physical-and-mental-health<br><br>Furthermore, a recent systematic review and meta-analysis of studies in the NHS and comparable health systems suggests that approximately one-third to two-thirds of people who attend A&E due to mental ill health have been known to mental health services.<br><br>A large majority of the people with most complex needs who attend A&E the most frequently are likely to have significant health needs including physical and mental co-morbidities, and may benefit from |

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| | assessment and review of care plans with specialist mental health staff, and further interventions from mental health, primary, community, social care, alcohol and substance misuse, and voluntary sector services.<br><br>Successful achievement of the CQUIN is therefore likely to necessitate partnership working and joint governance between CCGs, acute providers, mental health providers and other key local partners. Areas may wish to use existing forums such as A&E Delivery Boards and Urgent and Emergency Care Networks to oversee this process.<br><br>The CQUIN reward is to be shared between acute and mental health providers. CCGs will need to determine the allocation of the rewards locally, based on their local geographies, taking into account:<br><br>• the differing provider geographies (e.g. mental health providers may serve populations across the footprints of varying numbers of A&E departments);<br>• different arrangements in different areas – for example, some liaison services are provided by mental health trusts and some are provided by acute trusts;<br>• the milestones set out in the CQUIN – the achievement of which are contingent on actions from either mental health providers, acute providers, or both working together; CCGs will therefore need to consider and agree with providers the proportion of the indicators for each year that will be delivered by the acute provider(s), what proportion will be delivered by the MH provider(s), and what by both.<br>The CQUIN is for all ages – and it is for local areas to determine and segment the needs of the selected patient cohorts.<br><br>The cohorts of people who could benefit from case management, advance care planning and community interventions to help reduce A&E attendances, might typically include:<br><br>• People with primary substance misuse problems but with co-morbid mental health and social needs;<br>• People with long-term conditions (e.g. COPD, diabetes, heart failure, chronic pain syndrome) |

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| | which have a mental health component that has previously been undetected;<br>• Older people with a combination of multiple and deteriorating physical health problems, frailty, cognitive dysfunction and increasing social need;<br>• People with primarily complex mental health needs including self-harming behaviour, personality disorders, substance misuse;<br>• People with medically unexplained symptoms and resultant intensive health-seeking behaviours; and<br>• People with complex social needs, including e.g. housing, domestic violence, loneliness/social isolation, financial difficulties.<br>Nationally, coding of primary and secondary mental health needs in A&E is known to require considerable improvement. Anecdotally, we hear that people with mental ill health make considerable use of A&E, often staying there for long periods due to lack of alternatives (with frequent breaches of the 4hr A&E target) even though it is often not the best setting for them. Studies, such as those cited above also point to a considerable amount of undetected underlying mental health need among people presenting primarily for physical health reasons. However, poor coding means that it is not possible to quantify the scale or extent of this. It is in the clear interest of acute and mental health providers to improve the quality of data - not only to improve patient outcomes, but also to be able to demonstrate the true prevalence of mental ill health in A&E, and make the case for improved services.<br><br>Central to the CQUIN is the recognition that information sharing practices within the NHS itself and beyond need to improve, particularly for patients with mental health needs, in order to improve their experiences of care and outcomes. The issue of missed opportunities to share information in the interest of patient safety has also been raised by coroners on many different occasions following suicides and other serious incidents, with misplaced concerns about patient confidentiality often cited as a contributory factor. The information sharing practices encouraged by the CQUIN support the Caldicott Review's assertion that the duty to share information can be as important as the duty to protect patient confidentiality, and that health and social care |

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| | professionals should have the confidence to share information in the best interests of their patients.[8] [9] Information sharing agreements where they are not already in place should be expedited.[10] |
| **Data source** | A&E HES, Unify2 collection |
| **Frequency of data collection** | Quarterly submissions to commissioners relating to milestones set out below.<br><br>Single annual submission to NHS England |
| **Organisation responsible for data collection** | • Acute providers to collect data on cohorts (number of patients, number of attendances).<br>• Quarterly reports to CCGs.<br>• Annual national submission to NHS England. |
| **Frequency of reporting to commissioner** | Quarterly. |
| **Baseline period/date** | 2016/17 |
| **Baseline value** | A&Es to confirm number of people in the selected cohort and to calculate total number of attendances in 2016/17 for the selected cohort (including attendances per patient), and submit to NHS England via Unify2. |
| **Final indicator period/date (on which payment is based)** | Payment schedule as per milestones below. 2 year CQUIN scheme:<br>• Year 1 payment based on performance during 2017/18.<br>• Year 2 payment based on performance during 2018/19. |
| **Final indicator value (payment threshold)** | Year 1<br>• 20% reduction in A&E attendances of the selected cohort of frequent attenders to A&E in 2016/17 who would benefit from mental health and psychosocial interventions.<br><br>Year 2<br>• 0% increase in number of A&E attendances of the selected cohort of frequent attenders to A&E in 2017/18 who would benefit from mental health and psychosocial |

[8] Caldicott review: information governance in the health and care system: https://www.gov.uk/government/publications/the-information-governance-review

[9] NHS England, A Quick Guide to Sharing Patient Information for Urgent & Emergency Care: http://www.nhs.uk/NHSEngland/keogh-review/Documents/160203-qucik-guide-Sharing-Patient-Information-for-Urgent-Care.pdf

[10] The Information Governance Alliance (hosted by NHS Digital) and the Centre of Excellence for Information Sharing have produced helpful resources: http://systems.digital.nhs.uk/infogov/iga/resources/infosharing & http://informationsharing.org.uk/our-work/learning-good-practice/ & http://informationsharing.org.uk/our-work/resources/

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| | interventions.<br>• 10% reduction in all A&E attendances of people with a primary mental health diagnosis (when comparing Q4 2017/18 to Q4 2018/19). |
| **Final indicator reporting date** | Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes, in the milestones selection below. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes, in the partial achievement section below. |

## Milestones for indicator 4

| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
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| Q1 2017/18 | MH trust and acute trust to review most frequent A&E attenders who have attended 10-15 times or more within the last 12 months (i.e. throughout 2016/17).<br><br>Local acute and MH providers identify subset of people from most frequent A&E attenders who would benefit from assessment, review, and care planning with specialist mental health staff. Ways in which this can be done could include:<br>• Clinical review meetings between A&E and liaison mental health clinicians;<br>• Opportunistic assessment by liaison mental health clinicians (i.e. at one of the cohort patient's next attendances);<br>• Review of case notes.<br><br>Once this subset has been identified, the number of patients within it and the number of 2016/17 attendances is recorded to set a baseline.<br><br>MH trust and acute trust to assure commissioners that further work has been undertaken with partners (111, ambulance service, police, substance misuse, primary care, etc) to identify whether identified cohort also presenting frequently at other UEC system touch points. | June 2017 | 10% |

| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
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| Q2 2017/18 | MH trust and acute trust to work together to identify whether the presentations of the identified cohort were coded appropriately in A&E HES dataset.<br><br>Conduct internal audit of A&E mental health coding. On the basis of findings, agree joint data quality improvement plan and arrangements for regular sharing of data regarding people attending A&E. | Sept 2017 | 10% |
| Q2 2017/18 | MH trust, acute trust establish joint governance arrangements to review progress against CQUIN and associated service development plans. | Sept 2017 | 0% |
| Q2 2017/18 | MH trust, acute trust, to work with other key system partners as appropriate/necessary to ensure that:<br>• Care plans (co-produced with the patient and written in the first person) are in place for each patient in the identified cohort of frequent attenders;<br>• A system is in place to identify new frequent attenders and ensure that care plans are put in place swiftly;<br>• Care plans are shared with other key system partners (with the patient's permission). | Sept 2017 | 10% |
| Q2 2017/18 | MH trust, acute trust, bringing in other local partners as | Sept 2017 | 20% |

| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
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| | necessary/appropriate, agree service development plan to support sustained reduction in A&E frequent attendances by people with MH needs. This is likely to include enhancements to:<br>• Primary care mental health services including IAPT;<br>• Liaison mental health services in the acute hospital;<br>• Community mental health services and community-based crisis mental health services;<br><br>This work is likely to need to be undertaken with other partners outside of the NHS, including social care, public health and voluntary sector partners. | | |
| Q3 2017/18 | MH trust, acute trust review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via A&E HES data submissions is complete and accurate, to allow confidence that Q4 submissions are complete and accurate. Assurances provided to CCGs accordingly.<br><br>Mental health provider, acute provider to agree formally and assure CCG that they are confident that a robust and sustainable system for coding primary and secondary mental | Dec 2017 | 10% |

| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
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| | health needs is in place. | | |
| Q4/2017/18 | 20% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | March 2018 | 40% |
| Q1 2018/19 | Baseline set for total number of A&E attendances in Q4 2017/18 with primary mental health diagnosis.<br><br>Providers will need to submit aggregate data via UNIFY to demonstrate performance against the CQUIN. It is likely that the single end of year national UNIFY2 data submission to NHS England will include:<br>• Total number of A&E attendances of the selected cohort of most frequent attenders in 2016/17 who were identified as potentially benefitting from mental health and psychosocial interventions, and total number of these patients;<br>• Total number of A&E attendances of those within the selected cohort of most frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions, and total number of these patients;<br>• Total number of A&E | May 2018 | 0% |

| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
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| | attendances in Q4 2017/18 of people with a primary mental health diagnosis, and total number of these patients;<br>• Evaluation report of progress against all year 2017/18 milestones (as set out above), signed off by local A&E Delivery Board. | | |
| Q3 2018/19 | Repeat internal audit of A&E mental health coding to ensure improvement from year 1 is sustained.<br><br>Mental health provider, acute provider to agree formally and assure CCG that they are confident that a robust and sustainable system for coding primary and secondary mental health needs is in place. | Dec 2019 | 10% |
| Q4 2018/19 | Agree plan to mainstream CQUIN work programme to become business as usual going forward. | Jan 2019 | 0% |
| Q4 2018/19 | 0% increase in number of A&E attendances of the selected cohort of frequent attenders. | March 2019 | 10% |
| Q4 2018/19 | 10% reduction in A&E attendances with a primary mental health diagnosis in Q4 of 2018/19 as compared to baseline set in Q4 2017/18. | March 2019 | 80% |
| Q1 2019/20 | National data submission to NHS England via UNIFY2 for total number of A&E attendances during 2018/19 for those within the selected cohort of frequent attenders in 2017/18 who would benefit | May 2019 | 0% |

| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
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| | from mental health and psychosocial interventions.<br><br>Evaluation report of 2 year CQUIN submitted. | | |

## Rules for partial achievement of indicator 4

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
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| Year 1 – 15-19.99% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | 30% (maximum available is 40% for achieving 20%+ reduction) |
| Year 1 – 10-14.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | 20% |
| Year 1 – 5-9.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | 10% |
| Year 2 – 5-9.99% reduction in A&E attendances of all people with a primary mental health diagnosis. | 60% (maximum available is 80% for achieving 10%+ reduction) |
| Year 2 – 2.5-4.99% reduction in A&E attendances of all people with a primary mental health diagnosis. | 40% |
| Year 2 – 0-2.49% reduction in A&E attendances of all people with a primary mental health diagnosis. | 20% |