High Impact Actions to respond effectively to mental health demand through 999 and ambulance response.

NHS England and NHS Improvement

Contents

Background and engagement to date

There are significant concerns relating to pressures on ambulance services at present and the ability of the service to respond effectively to patient need.

Following a request from NHSE/I's national incident board in October 2021 the NHSE/I mental health team has carried out rapid engagement to develop a set of high impact actions for local areas to consider implementing to optimize their response to mental health demand through 999 and ambulance response.

Rapid engagement within 2 weeks has been undertaken with the following groups to inform this resource:

- Adult mental health patient and carer advisory group
- Ambulance trust mental health clinical leads
- Ambulance operational leads
- National ambulance service capacity panel
- Ambulance and mental health commissioners
- Mental health crisis clinical leads
- NHSX and NHSE/I digital leads
- Association of Ambulance Chief Executives
- NHSE/I regional mental health teams
- NHS Mental Health Chief Exec working group
- NHSE/I Central Ambulance Team

Summary: High Impact Actions for all areas to consider implementing this winter to improve response to mental health calls to 999

Actions to consider

1. Deploy mental health professionals who are dedicated to supporting people with mental health needs who call 999 (either co-located or remotely from 999 call centres);

2. Optional for areas who wish to pilot to agree MoUs locally to enable transfer of 999 mental health calls to 24/7 urgent mental health helplines, where people are calling with primary mental health concern and have no urgent physical needs (likely to be classed as category 3 or 4 calls);

3. All areas to profile 24/7 urgent mental health helplines on local Directory of Service (DOS);

4. Seek to increase local comms to ensure people are aware of local 24/7 urgent mental health helpline numbers, or it can be promoted at nhs.uk/urgentmentalhealth;

5. Where there are consistently problems for 999 services in accessing mental health crisis lines, local partners should ensure there is a regular a mechanism (eg crisis care concordat groups) to feed back constructively between ambulance and mental health services.

Please see following slides for further detail

Case for change

With unprecedented pressures facing 999/ambulance services, NHSE/I is asking mental health, urgent care and other system leaders to implement solutions as rapidly as possible this winter to improve response to people experiencing mental health crisis who call 999, by enabling them to access local mental health professionals as early as possible.

Data show that ~40% of all mental health attendances arrive to A&E by ambulance, compared to 25.5.% of all attendances. While some patients with mental health needs will need to be taken to A&E, this suggests an opportunity to support people who call 999 with mental health needs, to access local mental health support in the community rather than A&E which will not be the most therapeutic / preferred space for many people.

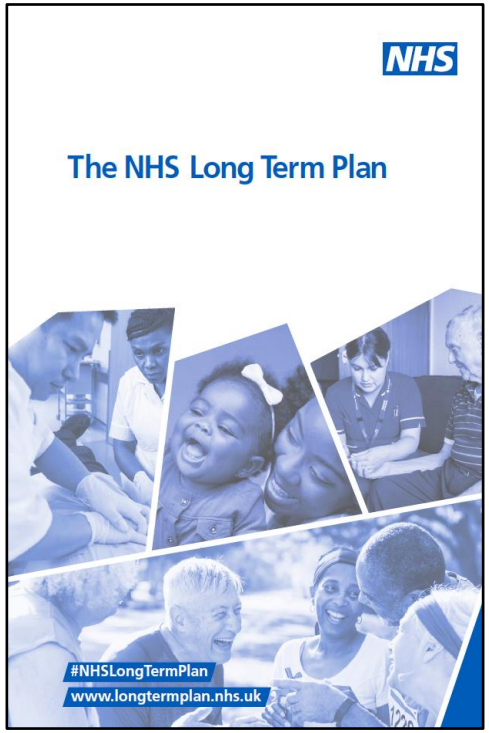
It is recognised that solutions for this winter while services that are facing significant pressures and recruitment challenges, will be imperfect. All areas are asked to consider what is feasible to support pressures in their local context to accelerate ambitions to improve this 'pathway' of care for mental health patients.

The aim would be to support 999 call handling pressures, and to avoid dispatching ambulances or conveyance to ED where this is not required or wanted by patients, but instead to provide access to specialist mental health support.

Further, earlier intervention from community mental health professionals, rather than direct escalation to ambulance, A&E or s.136 suites can also help to reduce avoidable mental health admissions and acute system pressures.

All areas should continue to implement the longer term transformation outlined in the NHS Long Term Plan.

NHS Long Term Plan: improving the ambulance response to mental health



Background:
The NHS LTP, published in January 2019, stated that 'Ambulance staff will be trained and equipped to respond effectively to people in a crisis'. This is in recognition of the significant role the ambulance service plays in responding to mental health calls and means that **for the first time there will be a dedicated national investment programme to improve capacity of the ambulance service to meet mental health (mental health) demand.**
This new programme for mental health and ambulance services includes the funding of mental health nurses and other mental health professionals working alongside colleagues in Integrated Urgent Care Clinical Assessment Services (CAS), Ambulance Emergency Operation Centres (EOC) and providing on-the-scene response. It also includes training for ambulance staff.
The NHS Mental Health Implementation Plan sets out more information on planning and delivery requirements, national funding and workforce pofiles and crucially, how improving the ambulance response to mental health contributes to developing comprehensive and well-functioning mental health crisis pathways for all ages.
Commissioning guidance is expected to be published in November and will be available here: https://future.nhs.uk/Adultmental health /view?objectId=22462128

Progress so far:
We are now in year 2 of 4 of LTP funding to increase mental health capacity in ambulance services. All ICSs have shown increased investment from 2020/21, which will continue through to 23/24 - with positive joint mental health and ambulance services emerging across the country (for example in Hampshire, Liverpool, Cambridge and London).
However, implementation has been slower than expected in many areas. (**See Annex A for ICS indicative vs planned spend**).
National and regional NHSE/I teams are working to support NHS 111, ambulance and mental health services to invest LTP monies and will continue to monitor progress against the ambition closely, with a view to delivering expected levels of investment by 23/24 as per the LTP aim.

- The following slides contain further considerations on the suggested high impact actions, including:
  - potential benefits (for systems, mental health providers and patients)
  - further description of the challenges and potential mitigations
  - case studies / good practice / support offer

Action 1: Deploy mental health professionals dedicated to receiving 999 mental health calls

Description

- this could be located remotely from 111/999 – e.g. with mental health crisis line staff located in the local 24/7 mental health crisis line function, but nominally dedicated to providing as responsive a service as possible to police and ambulance, with interoperable transfer of patient records;
- or this could be mental health staff co-located in the ambulance or integrated urgent care call centres, where 999 mental health demand would warrant this and there are sufficient staff to enable this.

It is recognised that staff trained in mental health telephone triage are in limited supply, so ICSs, ambulance and mental health services to consider how best to deploy staff as flexibly as possible to meet the totality of mental health demand that presents to crisis lines, 999 and NHS 111. Services should also consider access to trained children and young people (CYP) and learning disability and autism (LDA) professionals.

In considering this, mental health services should consider the relative safety risks for the local population of pressures on 999 services, and increased likelihood of people more quickly being escalated to A&E/ 136 / mental health admission when accessing care via 999.

Potential benefits

It is likely that many people with mental health needs accessing care via 999 end up:

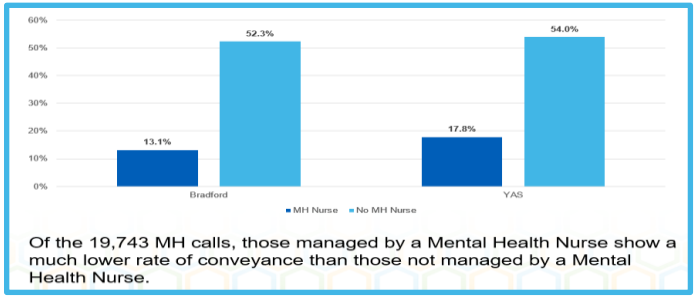
- speaking to professionals who aren't trained in mental health;
- are sent ambulances (that they may not want or have to wait long periods for);
- are conveyed to A&E which may not be the right setting for them or what they want;
- or get escalated straight to s136/ inpatient admission, potentially detained under the Mental Health Act, this might happen especially when mental health crisis services are not easily accessible to ambulance or police.

Intervening earlier will support mental health pressures too, as earlier intervention from community mental health professionals can enable more community-based options to be considered.

Having a dedicated mental health professional to support 999 should also improve triaging of mental health, providing parity of esteem for patients and will also be enabling existing mental health patients to speak to someone who has access to records, while still listening to needs of person in current crisis.

Case study / good practice – Yorkshire Ambulance Service 2018 pilot

Mental health nurses deployed into 999 Emergency Operations Centre (see full case study on slide 19, in Annex C and AACE online repository)



Of the 19,743 MH calls, those managed by a Mental Health Nurse show a much lower rate of conveyance than those not managed by a Mental Health Nurse.

Action 1: Deploy mental health professionals dedicated to receiving 999 mental health calls

Challenges and potential mitigations

Crisis lines not sufficiently resourced to meet demand and there are challenges with recruitment	• Consider recruiting VCS, assistant psychology, values-based recruitment of non-registered staff to add capacity to telephone triage function. • Unregistered staff with training and the right ethos (with supervision) may add capacity providing listening support, administrative functions, and free capacity of registered staff to handle more complex calls or provide urgent face to face response.
Significant numbers of mental health staff unlikely to be recruited in time for this winter to support these aims	• This winter it may require careful redeployment of existing mental health staff to support 999 mental health demand, or dedicating some staff to supporting patients presenting to police/ambulance. • Pressures are likely to remain beyond this winter, and this is part of longer term transformation – so additional capacity is likely to have enduring benefits this winter and beyond
Pressures on mental health services means there is sometimes a lack of system level collaboration (1)	• Work as a 'system' issue in partnership, including sharing respective safety issues / pressures faced by 999 and mental health crisis lines. (e.g. safety risk to local population of long 999 waiting times is a system issue, not just an ambulance service problem) • Mental health services will want to support patients to avoid poor experiences of having to wait for ambulances or in A&E if it can be avoided.
Pressures on mental health services means there is sometimes a lack of system level collaboration (2)	• Mental health services also likely to understand that intervening earlier will support mental health pressures too. 999 mental health calls may be likely end up in mental health services in any case but at the more acute / restrictive end of services – people who call 999 are more likely to end up in A&E/ s.136/ and therefore inpatient admission, when earlier intervention from community mental health professionals could have enabled more community-based options to be considered.

Action 2: Optional for areas who wish to pilot to agree MoUs locally to enable transfer of 999 calls to urgent mental health helplines

Description

Areas can decide to pilot the agreement of MoUs locally to enable transfer of 999 calls to 24/7 urgent mental health helplines, where people are calling with primary mental health concern and have no urgent physical needs. (Likely to be what would be classed as category 3 and 4, and where it is clear that it is a mental health concern). This is optional and if areas wish to find out more, please contact england.adultmh@nhs.net so that more detailed guidance can be shared on how to implement this in practice.

- This may work well with recent work carried out by ambulance trusts to carry out clinical validation of mental health calls.
- Likely to be most feasible where mental health crisis lines have capacity to meet additional demand
- From a technical/digital perspective it is likely to be most feasible in ambulance trusts that use the 'NHS Pathways' system:
    - NHS pathways: the call and patient notes are transferred using the mental health helpline's DOS profile (5 ambulance trusts)
    - But also feasible in systems that use Advanced Medical Priority Dispatch System (AMPDS): In this instance the call handler has local crisis line numbers to hand, (or manually searches for local crisis line based on NHS.UK postcode search) and inputs patient details into 111 system (5 ambulance trusts)
        - As a workaround, a guided voice transfer may be facilitated using an external service advisor, to avoid people having to tell their story repeatedly and to ensure call handlers are not tied up for long periods effecting the transfer.
- More simply, it has become apparent that some ambulance staff are not aware of local 24/7 crisis lines or do not try to access them, so at a minimum, all should be aware of local mental health crisis lines and have the numbers available

To ensure the patient receives support, strong governance about handover of clinical responsibility of patients will need to be agreed. MH and ambulance operational leads will need to provide regular feed back to each other to improve how the transfers are being made.

A shared understanding of relative risks in the local system to be agreed between 999 and urgent mental health services.

A similar approach is being developed through the 100 day challenge. Over 40 2 hour physical health community response services are working with the ambulance sector to more appropriately see some of the category 3 and 4 calls 999 calls to work collaboratively please join the collaborative platform or email england.ageingwell@nhs.net to be connected to 2 hour physical health community response local teams.

Potential benefits

999 ambulance services are under extreme, unprecedented pressures, with very significant level of concern around risk and safety to the public, especially as we are not yet at the winter peak.

By enabling a transfer from 999 to urgent mental health crisis lines, patients are more likely to have access to potential avenues of support from community mental health crisis services.

Case studies / good practice / support offer

NHSE/I is currently seeking 3-4 sites who are willing to pilot a system whereby CAT 3 and 4 mental health calls are transferred to crisis lines. We will work with local systems to undertake detailed learning (including how CAT 3 and 4 is triaged) with the potential development of a national MoU for local areas to adopt, should they wish to trial this approach as well.

To understand digital needs (e.g. ITK link, assessment pro-forma etc) associated with effecting the transfer, we may need to hold a national workshop led by digital teams.

Action 2: Optional for areas who wish to pilot to agree MoUs locally to enable transfer of 999 calls to urgent mental health helplines

Challenges and potential mitigations

Effecting the transfer might take longer than managing the call and inadvertently increase pressures.	• Having mental health professionals working directly in the ambulance call centre or dedicated to ambulance response will enable quicker access to appropriate mental health support. • Service advisors may be able to lend capacity to transferring calls.
Must be a transfer, not passing people from pillar to post while in crisis.	• MoUs to be clear that people in mental health crisis should not be passed another number to call but facilitate access to the right service. • Where this is taking too long, there needs to be active feedback loops between senior operational leads in mental health crisis lines and ambulance call centre. • Or for example where it is not immediately urgent, the ability for ambulance service to book in call back from mental health crisis line / professional if the patient chooses that rather than waiting and it is deemed safe to do so.
Cat 3 can include suicidal people	• Ambulance call handling staff who aren't mental health trained are (understandably) likely to be more risk averse. • Rapid access to a mental health professional is needed so they can safely assess the risk / urgency and type of response needed. • The National Education Network for Ambulance Services (NENAS) is scoping and will develop training modules to support client facing ambulance staff to better support people with mental health problems, including those experiencing suicidal thoughts – available in 22/23.
Its not clear in some patients whether they have complex set of physical / mental needs	• For purposes of rapidly supporting pressures this winter, to focus any efforts to transfer care only for those mental health patients that are clearly calling with mental health needs, but without co-existing physical needs.

Action 3: All areas to profile 24/7 urgent mental health helplines on DOS

Description

All areas to profile 24/7 urgent mental health helplines on Directory of Services (DOS), in line with DOS profiling guidance issued in 2020, which describes a standardised approach to profiling, based on national mental health starter and stretch templates and existing urgent mental health 24/7 helpline services.

The DOS Lead for each area will be responsible for ensuring that there is a 24/7 urgent NHS mental health helpline service DOS profile for each mental health crisis care support service in their DOS region. Service demographic information key contacts can be found here.

A national 'Urgent NHS Mental Health Helpline' DOS service template is available here. The template has been developed collaboratively and signed off nationally by the commissioners (i.e. NHS England and NHS Improvement). The clinical profile is based on existing crisis care telephone support services and will be subject to regular reviews.

NB Where services are already established and profiled on DOS, these should be re-named and reviewed against the *Service* Template – MH: Urgent NHS Mental Health Helpline and amended as appropriated.

Potential benefits

The 999 service should have an up to date and complete DOS of NHS, LA and VCS services and ideally have good relationships and understanding of the local teams and services to whom they might signpost / refer people. This will enable patient access to a range of mental health professionals to meet different needs eg nurses, psychiatrists, peer support workers, trained people who can listen and show compassion.

All areas will need to profile crisis lines onto the DOS to achieve the Long Term plan commitment to move towards NHS 111 becoming the single point of access (SPoA) for people experiencing mental health crisis.

Challenges and potential mitigations

'Othering' of mental health / parity

- All comms should be clear that mental health patients, like all patients, should only call 999 in emergency, and that when it is a mental health emergency, 999 is the right option.
- This work must not be about 999 rejecting people, rather 999/mental health services to work together to help people get to the right care as soon as possible.

Crisis line capacity

- Commissioners should aim to keep demand and capacity under regular review to ensure that calls do not go unanswered, or people don't experience long waits.
- If a call is not answered by receiving service, mechanisms should be in place to route the call back to the 'core' NHS 111 service. Further discussions are required with service users and clinicians to determine appropriate timeframe

Case study / good practice / support offer

More detail and considerations are provided via the NHS Future Collaboration Platform.

Action 4: Increase local comms to ensure more people are aware of local 24/7 urgent mental health helpline numbers

Description

Seek to increase local comms to ensure more people are aware of local 24/7 urgent mental health helpline numbers, or it can be promoted at nhs.uk/urgentmentalhealth

- All areas now have 24/7 NHS urgent mental health helplines that have been established for at least 18 months. However, people may not be aware of these, and instead end up calling 999 when experiencing a mental health crisis or when they don't get the support they need from these lines.
- Media and social media commentary and engagement with patient advisory groups, suggests low levels of awareness of the crisis line offers across the country.
- Ambulance services have also indicated that they are unaware of these helplines, so areas will need to increase comms to local system partners.

Potential benefits

The crisis lines are viewed as a way of meeting needs before crisis point where someone might naturally call 999 / attend A&E or end up needing a mental health bed.

Increasing comms to system partners fosters good relationships and understanding of the local teams and services to whom they might signpost / refer people.

Challenges and considerations

Crisis line capacity

- Consider recruiting VCS, assistant psychology, values-based recruitment of non-registered staff to add capacity to telephone triage function.

Success dependent on alternative options locally to support people experiencing mental health crisis

- Continue Long Term Plan expansion of crisis services for home visits or alternative safe spaces. Winter funding may be used to expand capacity and ensure alternatives available.
- Explore models of mental health safe spaces / crisis assessment centres that provide safe mental health spaces for conveyance

Case study / good practice / support offer

A national announcement about the crisis lines went live in July 2021: https://www.england.nhs.uk/2021/07/nhs-mental-health-crisis-helplines-receive-three-million-calls/

Action 5: ICSs should ensure there is a regular a mechanism to constructively address issues

Description

Where there are consistently problems in 999 services accessing crisis lines, **ICS should ensure there is a regular a mechanism (eg crisis care concordat groups) to feed back constructively to mental health services in difficulties accessing crisis lines**, in order that this can be addressed.

- This will ensure that feedback from busy operational staff is escalated to the right level where it can be considered and addressed strategically .
- Where local mental health crisis line capacity is such that they are unable to provide a responsive service, a process should be established so that ambulance and police feedback, for example via the local crisis care concordat or similar governance mechanisms in the ICS, so that it can be addressed in future.

Potential benefits

Having mechanism in place for open and honest feed back, without blaming each other can help services to build relationships, understand each other's perspectives and ultimately improve services for patients.

Challenges and considerations

Demand at certain times of day means that is when there will be most difficult

- Use Erlang methodology to identify staffing levels at certain times of day
- Consider possibility of redeploying / diverting / adding staff during specific shifts (eg evening/twilight)
- Potentially to agree alternative protocols at busier / less busy times

Case study / good practice / support offer

The Mental Health Crisis Care Concordat is a national agreement between local services and agencies involved in the care and support of people in mental health crisis. It sets out how organisations will work together better to make sure people get the help they need when they need it.

Seasonal pressures funding is available to support urgent and emergency care pressures:

Seasonal pressures funding:
All ICSs will receive **a fair-shares portion of a further £19m for seasonal pressures,** which has been identified and rediverted from other areas to support urgent care pressures. (This is in addition to Long Term Plan and 2021/22 Spending Review funding).

Funding can be used flexibly which includes being used to **Pilot / embed / extend hours of new models of A&E diversion and alternative to admission, including:**

- mental health staff into 999 emergency operation centres (either co-located or remotely) to support mental health calls to 999, diversion of mental health calls to crisis lines with aim of facilitating access to mental health services and to reduce avoidable deployment of ambulance or conveyance to ED

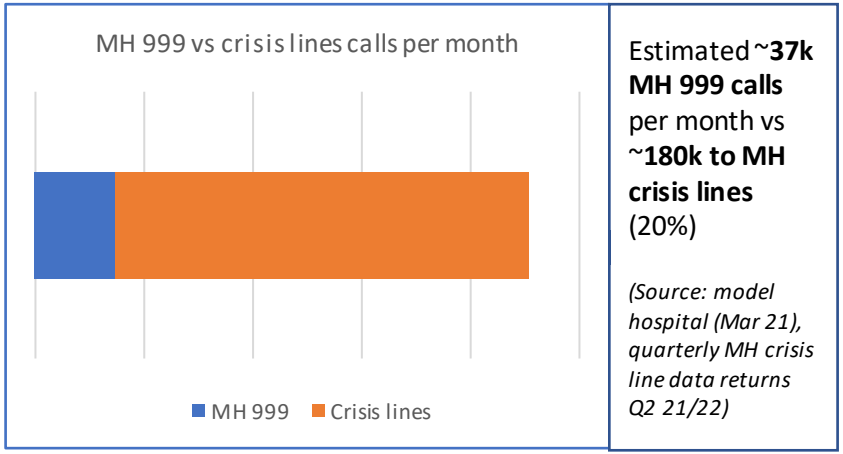
- Increase capacity of crisis lines – e.g. recruit assistant psychology, VCS, and other support staff (including peer support) to support telephone triage function, and to free qualified clinical staff on f2f assessment and home treatment

- Liaison staff at front door of ED to support access to more suitable alternatives, informed by expert mental health assessment (model has shown promise in some areas)

- Crisis alternatives –extend provision of sanctuaries, crisis cafes, crisis houses/beds, urgent mental health care centres, day hospitals, Service-User led crisis services

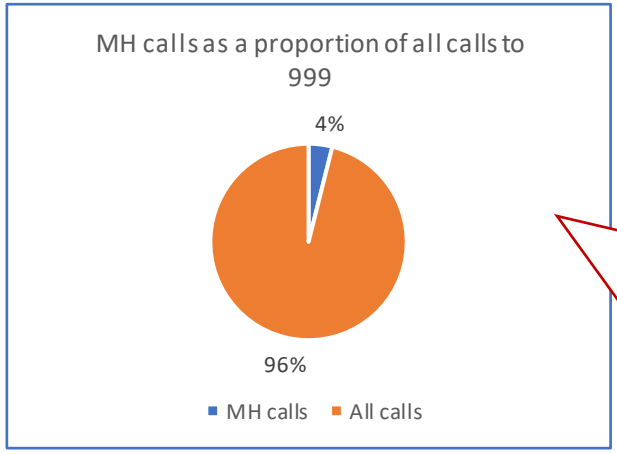
- Bolster home treatment/crisis response to ensure as many episodes of care at home as possible

Data: summary of what we know on MH 999 calls and conveyance to ED



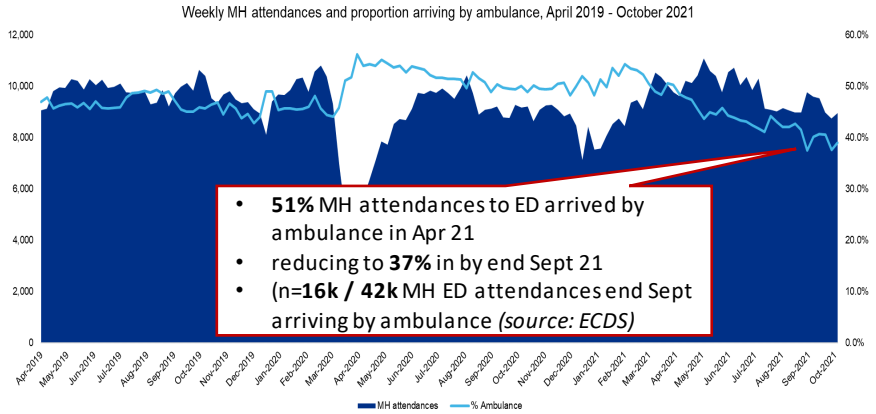
Estimated **~37k MH 999 calls** per month vs **~180k to MH crisis lines** (20%)

(Source: model hospital (Mar 21), quarterly MH crisis line data returns Q2 21/22)

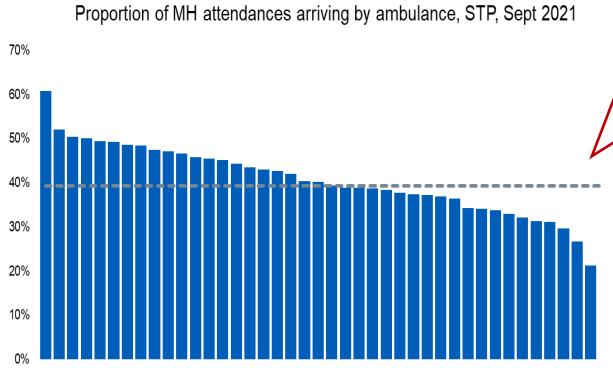


Estimated **~37k MH 999 calls** per month vs **~947k all calls to 999** (4%)

(Source: model hospital (Mar 21), NHSE/I ambulance quality indicators (Sept 21)



- **51%** MH attendances to ED arrived by ambulance in Apr 21
- reducing to **37%** in by end Sept 21
- (n=**16k / 42k** MH ED attendances end Sept arriving by ambulance *(source: ECDS)*



- Significant variation by ICS in % of MH attendances to ED who arrive by ambulance
- Sept: national % higher for MH (39%) than non-MH (25%)

(source: ECDS)

Suggests opportunity to divert MH demand from ED in many places

Local good practice examples of joint mental health and ambulance / 999 services

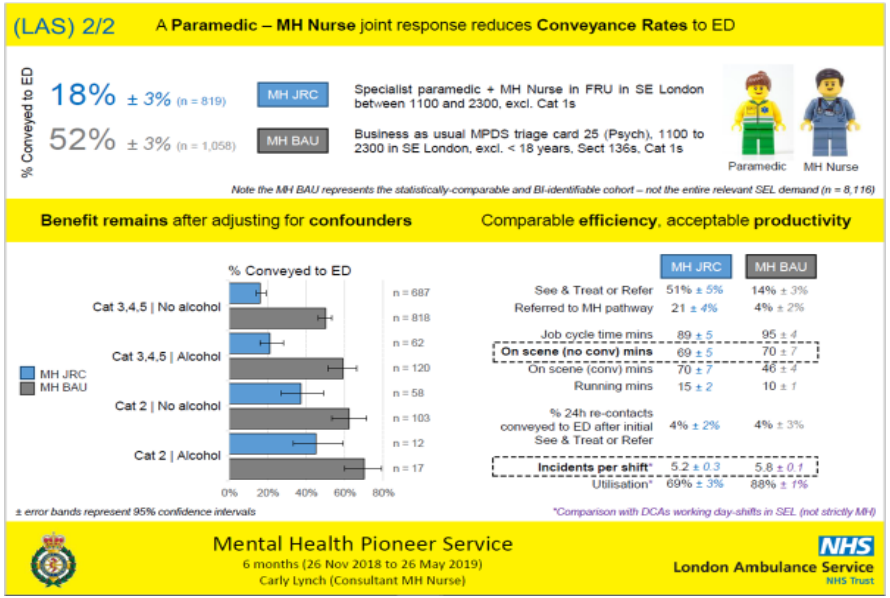
NHSE/I collated and shared positive practice examples from most NHS Ambulance services, outlining their different responses to mental health demand in their area.

These examples were provided to aid local planning for use of the additional funding that has been provided to CCGs, for the ambitions to improve ambulance service mental health response as outlined in the NHS LTP and the NHS Mental Health Implementation Plan. The full case study pack has been included in Annex C.

Some positive practice models, and their impact, have been highlighted on the next two slides and are intended to aid LTP investment locally, but not necessarily a high impact action that can be put in place at pace this winter.

London Ambulance Service: Paramedic and Mental Health Joint Response Car (mental health JRC)

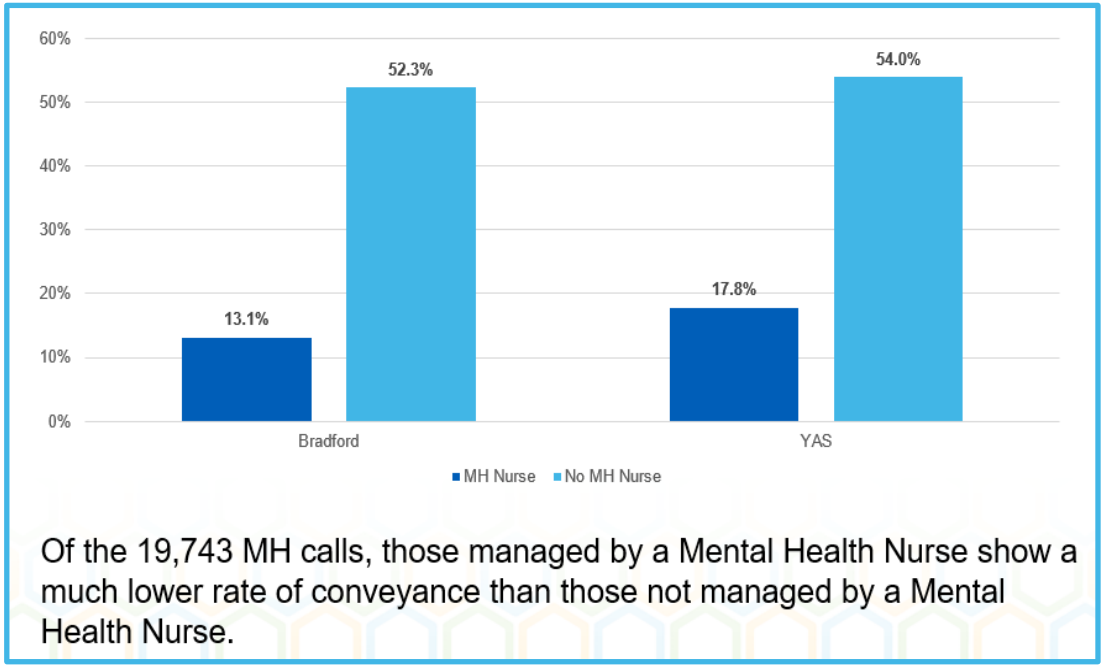
- Mental Health (mental health) Nurse and Paramedic dispatched as First Response to patient identified as being in a Mental Health Crisis and requiring a face to face assessment.
- The Mental Health Professional provides enhanced biopsychosocial assessment and risk assessment. The Paramedic brings their expertise in pre-hospital care and physical health assessment and examination.
- Model has also resulted in upskilling and increased confidence of ambulance staff who rotate onto mental health JRC and work alongside mental health professionals.



Local good practice examples of joint mental health and ambulance / 999 services

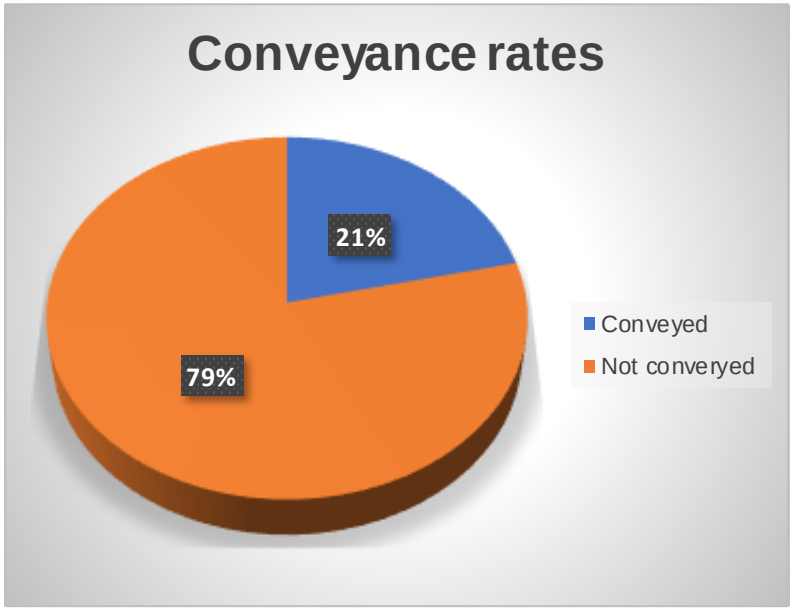
Yorkshire Ambulance Service: Mental Health Nurses in Emergency Operations Centre

- A team of mental health nurses have been deployed to:
- Pick up calls that come in for mental health issues, self-harm, suicidal intent.
- Support crews on scene to manage mental health patients.
- Work with despatch on scene safety issues.
- Work with suicidal patients while crew is despatched and while on scene.
- Support 111 mental health calls.
- Support crews with Mental Capacity Act decisions on scene.
- Develop frequent caller mental health care plans.
- Access background information to support crews on scene.
- Support crews with difficult and challenging behaviours or ABD.
- Support police calls.
- Support decision making.



Of the 19,743 MH calls, those managed by a Mental Health Nurse show a much lower rate of conveyance than those not managed by a Mental Health Nurse.

Local good practice examples of joint mental health and ambulance / 999 services



Cambridge and Peterborough Mental Health Trust (CPFT) and East of England Ambulance Service – Mental Health Joint Response Car (mental health JRC)

The mental health JRC launched on 19th January 2021 and has attended over 200 mental health calls (averaging 2.5 calls per shift). The mental health JRC operates from 3pm -1am daily covering the whole of the Cambridge and Peterborough.

This is a jointly funded project with money from the CCG diverted to both EEAST and CPFT; CPFT provide the mental health nurse and EEAST provide the paramedic and the Rapid Response Vehicle. The mental health nurse is still employed by and reports to CPFT whilst the paramedic remains under the governance structure of EEAST.

- Mental health Nurse and EEAST paramedic dispatched to patients in the community identified as being in a mental health crisis.
- Providing a holistic physical and mental health triage in the community to try and avoid unnecessary attendances at acute hospitals.
- The mental health JRC responds to 999 calls to the ambulance service that have been coded as a mental health call and also offers face to face or telephone advice to crews on scene at jobs which have a primary mental health need.
- The mental health nurse offers training to EEAST crews around common mental health presentations and the Mental Capacity Act.

79% of people seen by the mental health JRC have not been conveyed to an acute hospital. Of those who have been conveyed (no. 98), 50% needed to attend an acute hospital for a physical health need.

Next steps and potential metrics to review models

- All ICS to bring ambulance and mental health services together to seek to implement actions in this pack as soon as possible, with a view to rapid actions to support winter (and avoiding any lengthy contracting, overly onerous business cases etc.) We will be seeking updates on joint mental health and ambulance working via the Q3 assurance template.
- National Urgent and Emergency Care and Mental Health teams to confirm and work closely with 3-4 areas with to gather more detailed learning about implementing the action 2 set out in this pack, with a view to sharing further learning
- Share further guidance for commissioners to support implementation of the Long Term Plan ambition to encourage commissioning of ambulance / mental health models in all ICSs in the longer term .

Potential metrics to track impact of LTP ambitions

- Time to provide the initial clinical response to all MH patients
- Time to provide the initial clinical response to S136 patients
- Time to provide an initial MH assessment (either remotely or on scene)
- How and by whom MH patients are conveyed following s.136
- The proportion of MH patients who were conveyed/not conveyed to ED
- Where MH patients were conveyed to

Qualitative
- Experience of staff and patients

Specific suggested local measures to assess effectiveness of transfer of calls

- Transfers back into ambulance
- Safety incidents
- Re-contact (from same number)
- Call length time
- Before and after call volume data / conveyance data
- % offered warm transfer who refuse it

Qualitative
- Experience of staff and patients

Annex A – ICS indicative vs planned LTP funding

Planned vs indicative cumulative growth 2019/20 – 2021/22 by ICS

Region	STP	Ambulance response services (£'000s)		
		Planned growth 2019/20 - 2021/22	Indicative Growth 2019/20-2021/22 as per LTP analytical tool	Proportion of indicative growth 2019/20-2021/22
South West	Devon	1,186	790	150%
Midlands	Birmingham and Solihull	0	816	0%
North West	Cheshire and Merseyside	334	1,829	18%
London	North West London Health and Care Partnership	711	1,368	52%
Midlands	Northamptonshire	204	451	45%
Midlands	The Black Country and West Birmingham	593	945	63%
Midlands	Coventry and Warwickshire	0	594	0%
South East	Buckinghamshire, Oxfordshire and Berkshire West	256	989	26%
North West	Healthier Lancashire and South Cumbria	626	1,210	52%
North West	Greater Manchester Health and Social Care Partnership	67	2,021	3%
East of England	Hertfordshire and West Essex	80	911	9%
South West	Somerset	291	376	77%
South East	Kent and Medway	639	1,158	55%
North East and Yorkshire	South Yorkshire and Bassetlaw	1,451	1,004	145%
Midlands	Nottingham and Nottinghamshire Health and Care	229	668	34%
East of England	Norfolk and Waveney Health and Care Partnership	204	677	30%
London	East London Health and Care Partnership	680	1,259	54%
London	Our Healthier South East London	240	1,185	20%
London	South West London Health and Care Partnership	-43,261	908	-4763%
South West	Bristol, North Somerset and South Gloucestershire	206	591	35%
North East and Yorkshire	Cumbria and North East	710	2,152	33%

- Variation between ICS' investment over two years but money is being spent in most ICSs
- South West London – error in plan

Planned vs indicative cumulative growth 2019/20 – 2021/22 by ICS

Region	STP	Ambulance response services (£'000s)		
		Planned growth 2019/20 - 2021/22	Indicative Growth 2019/20-2021/22 as per LTP analytical tool	Proportion of indicative growth 2019/20-2021/22
South East	Surrey Heartlands Health and Care Partnership	120	624	19%
East of England	Mid and South Essex	361	732	49%
North East and Yorkshire	Humber, Coast and Vale	648	1,084	60%
Midlands	Shropshire and Telford and Wrekin	0	315	0%
Midlands	Staffordshire and Stoke on Trent	265	731	36%
East of England	Suffolk and North East Essex	253	638	40%
London	North London Partners in Health and Care	592	951	62%
Midlands	Herefordshire and Worcestershire	0	490	0%
South West	Cornwall and the Isles of Scilly Health and Social Care Partnership	0	391	0%
Midlands	Joined Up Care Derbyshire	250	661	38%
South East	Hampshire and the Isle of Wight	446	1,144	39%
South West	Bath and North East Somerset, Swindon and Wiltshire	743	557	133%
North East and Yorkshire	West Yorkshire and Harrogate (Health and Care Partnership)	791	1,581	50%
East of England	Bedfordshire, Luton and Milton Keynes	349	589	59%
South West	Gloucestershire	60	387	16%
East of England	Cambridgeshire and Peterborough	253	530	48%
South East	Frimley Health and Care ICS	99	435	23%
South West	Dorset	-336	518	-65%
Midlands	Leicester, Leicestershire and Rutland	692	631	110%
South East	Sussex Health and Care Partnership	0	1,112	0%
Midlands	Lincolnshire	0	505	0%

- New programmes often take a couple of years to become established and for money to flow – more complex working across multiple partners in the system
- Flexible ambition – we need to meet investment by 23/24 but trajectory towards that is determined locally

Planned vs indicative cumulative growth 2019/20 – 2021/22 by region

	Ambulance response services (£'000s)		
	Planned growth 2019/20 - 2021/22	Indicative Growth 2019/20-2021/22 as per LTP analytical tool	Proportion of indicative growth 2019/20-2021/22
East of England	1,499	4,077	37%
London	-41,038	5,670	-724%
Midlands	2,233	6,807	33%
North East and Yorkshire	3,600	5,822	62%
North West	1,027	5,060	20%
South East	1,561	5,462	29%
South West	2,150	3,610	60%
National	-28,968	36,508	-79%

- London and national total planned and % showing disinvestment due to South West London error
- Variation between regions but all show investment over two years

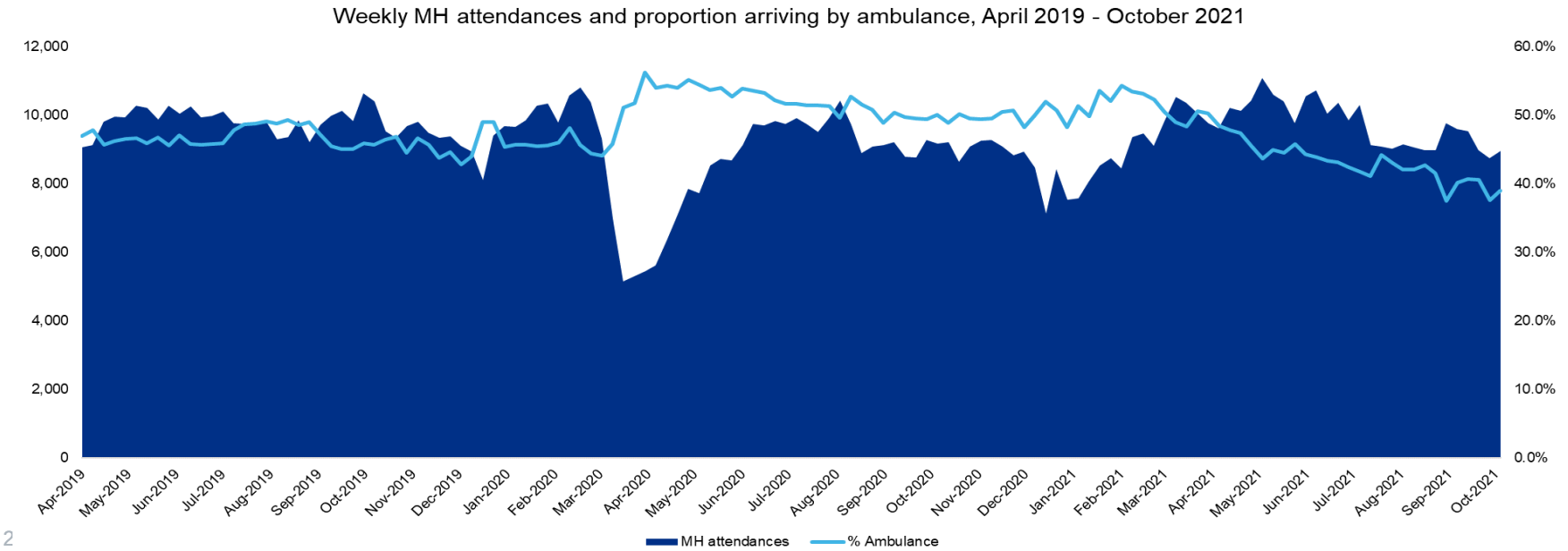
Annex B - ECDS Ambulance mental health data

October 2021

NHS England and NHS Improvement

mental health Ambulance Arrivals over Time

- The proportion of mental health attendances arriving by emergency ambulance peaked at almost 56.0% in April 2020 and remained at around 50% for the next 12 months.
- **Since April 2021 the proportion of mental health attendances arriving by ambulance has been decreasing from 51% in April 2021 to 37% at the start of October 2021.**
- This may reflect increased investment in emerging models of ambulance / mental health joint response with some examples of successful diversion of mental health patients away from ED to other more suitable options of support for mental health needs



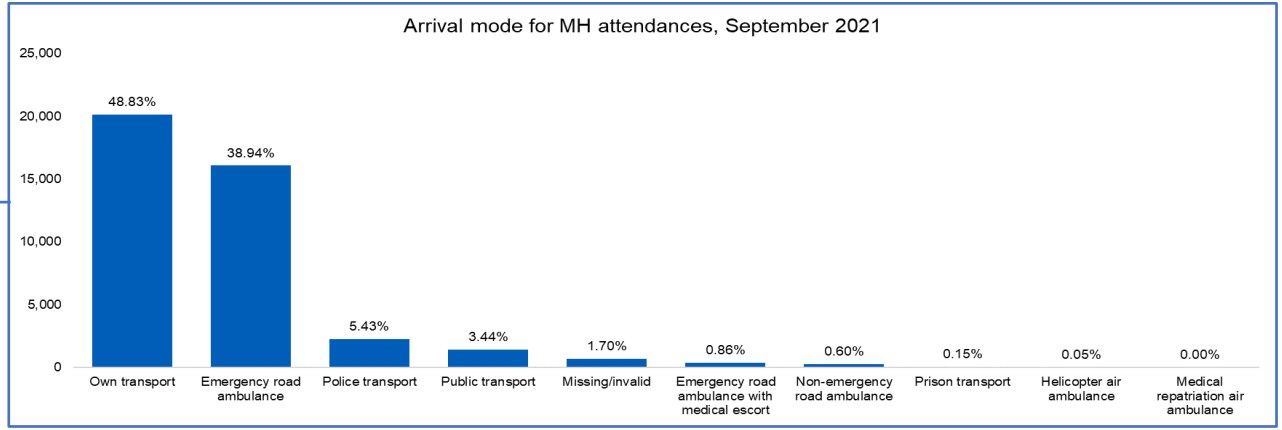
Data: Mental health arrival to A&E by ambulance, and compared to all attendances (ECDS)

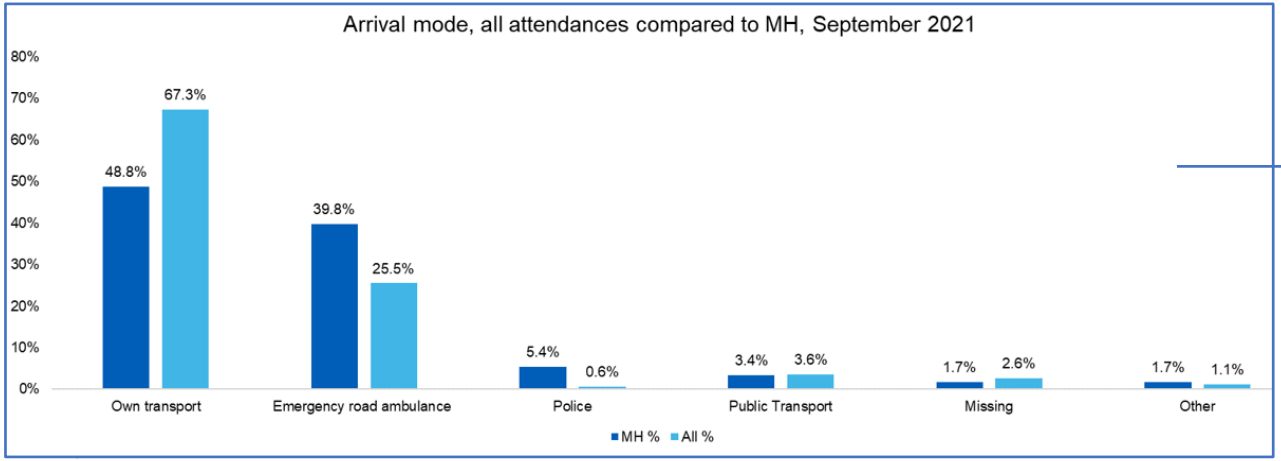
There were 1.4 million attendances to Type 1 A&Es in September 2021.

Of these, 41,200 (2.9%) were mental health related, based on chief complaint, diagnosis and injury intent.

Most mental health attendances arrived by own transport (49%) and **39% arrived by emergency road ambulance.**

This equates to around **16,000 mental health conveyances to ED in Sept 2021**





Compared to the arrival mode for all A&E attendances in this period, **mental health attendances appear more likely to arrive by ambulance** than other attendances, (and less likely to arrive by own transport)

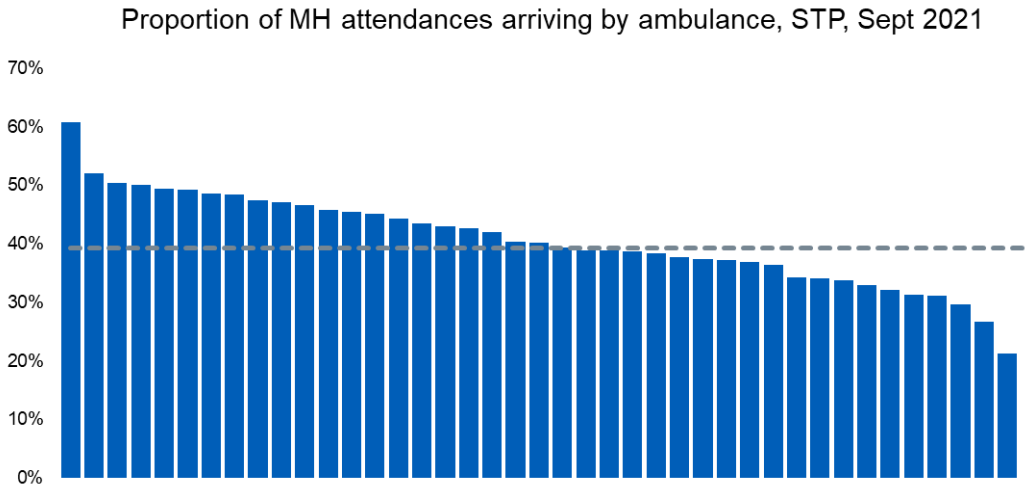
While some patients with mental health needs will need to be taken to A&E, this suggests an **opportunity to support people who call 999 with mental health needs, to access local mental health support in the community rather than A&E** which will not be the most therapeutic / preferred space for many people

Mental health attendances are almost 10 times more likely to arrive by police

Ambulance mental health arrivals to ED by ICS

- At ICS level, the proportion of mental health attendances which arrived by ambulance ranges from 0.0% (Gloucestershire) to 6 0.8% (Staffordshire and Stoke on Trent) in September 2021.

- While some attendances to ED will remain appropriate, this suggests variation in how mental health calls to 999 are triaged and directed, and/or availability of alternative options to A&E for people experiencing mental health crisis.

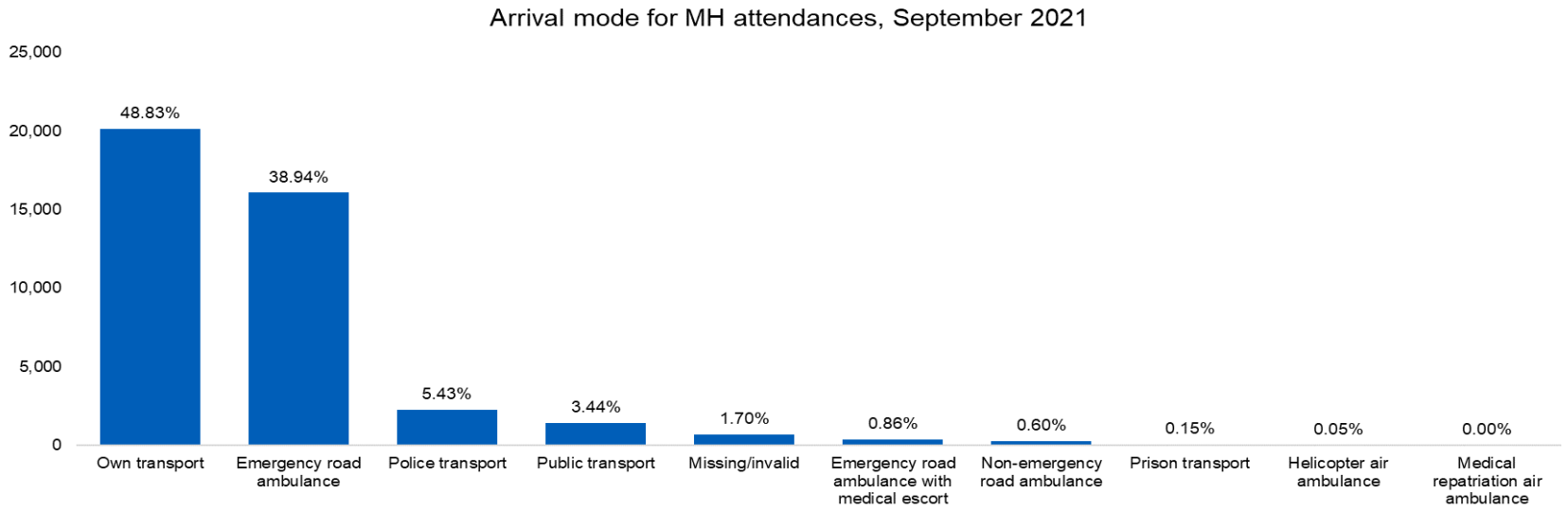


	STP	Via ambulance (%)
1	Staffordshire and Stoke on Trent	60.8%
2	Hampshire and Isle of Wight	52.0%
3	Cornwall and the Isles of Scilly	50.4%
4	Herefordshire and Worcestershire	50.1%
5	Birmingham and Solihull	49.4%

	STP	Via ambulance (%)
48	Lincolnshire	31.2%
49	North London	29.7%
40	Bedfordshire, Luton and Milton Keynes	26.7%
41	Kent and Medway	21.2%
42	Gloucestershire	0.0%

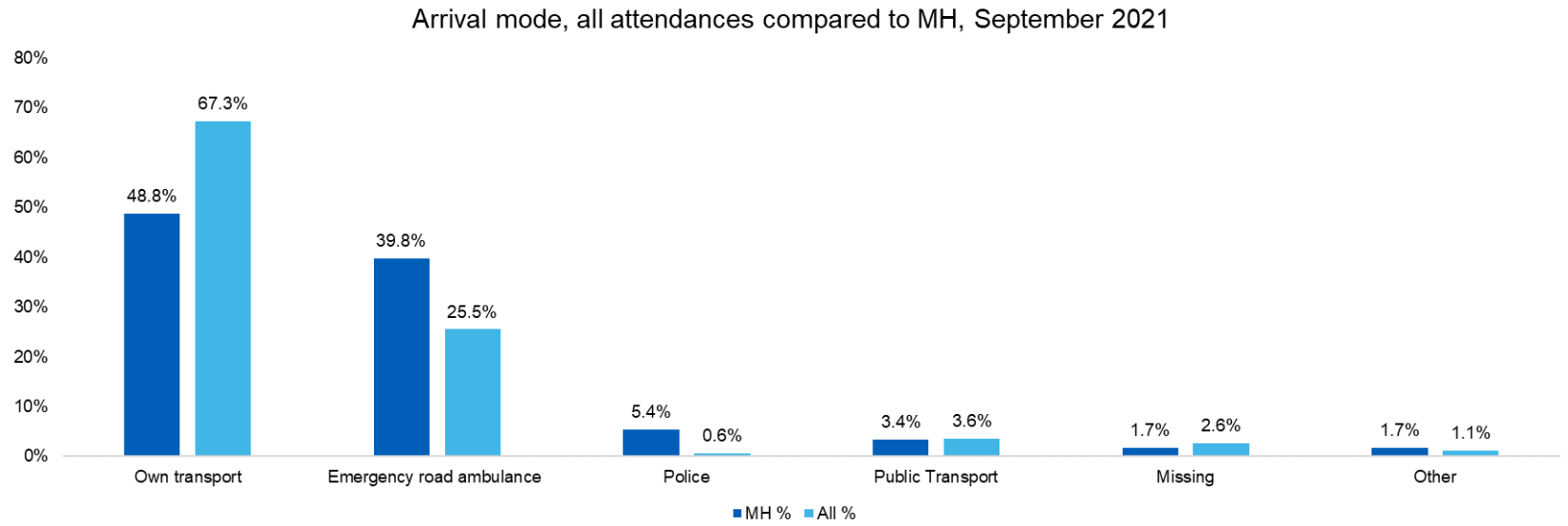
Mental health arrival to A&E by ambulance (ECDS)

- There were 1.4 million attendances to Type 1 A&Es in September 2021.
- Of these, 41,200 (2.9%) were mental health related, based on chief complaint, diagnosis and injury intent.
- Most mental health attendances arrived by own transport (49%) and **39% arrived by emergency road ambulance.**
- This equates to around **16,000 mental health conveyances to ED in Sept 2021**



Mental Health arrivals to ED compared to all attendances

- Compared to the arrival mode for all A&E attendances in this period, **mental health attendances appear more likely to arrive by ambulance** than other attendances, (and less likely to arrive by own transport)
- While some patients with mental health needs will need to be taken to A&E, this suggests an **opportunity to support people who call 999 with mental health needs, to access local mental health support in the community rather than A&E** which will not be the most therapeutic / preferred space for many people
- mental health attendances are almost 10 times more likely to arrive by police



Ambulance calls with mental health symptom group, by ambulance trust (March 2021, model hospital)

Ambulance Trust	**Number of recorded mental health calls, March 2021**
East Midlands Ambulance Service NHS Trust	3267
South Western Ambulance Service NHS Foundation Trust	3696
West Midlands Ambulance Service University NHS Foundation Trust	7197
Isle of Wight NHS Trust	52
South Central Ambulance Service NHS Foundation Trust	1235
Yorkshire Ambulance Service NHS Trust	3429
North West Ambulance Service NHS Trust	5253
South East Coast Ambulance Service NHS Foundation Trust	3537
East of England Ambulance Service NHS Trust	4272
London Ambulance Service NHS Trust	3822
North East Ambulance Service NHS Foundation Trust	1463

Data quality caveats: different recording practices in ambulance trusts, and likely to be missing many calls where the primary call out was for a physical health need (but there may have been a co-occurring mental health need (eg overdose)