Royal College of Emergency Medicine

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Royal College of Emergency Medicine's response to the House of Lords Public Services Committee: Access to Emergency [1]Services Inquiry

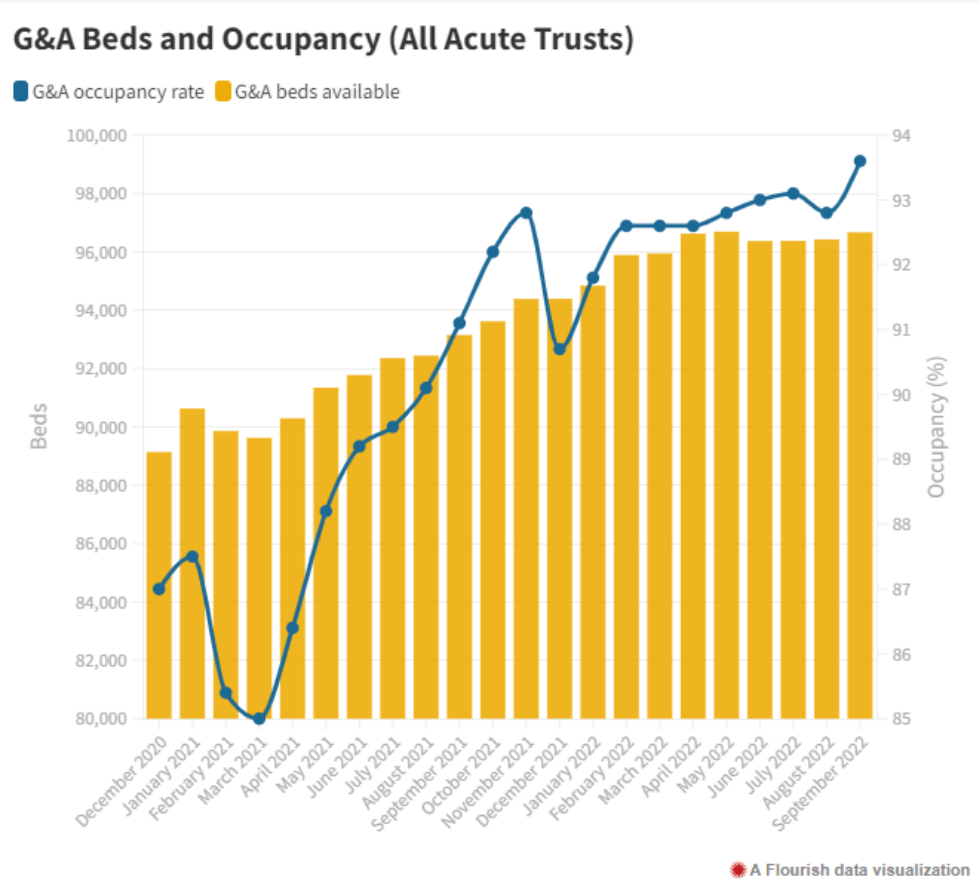
October 2022

About the Royal College of Emergency Medicine

The Royal College of Emergency Medicine (RCEM) is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides clinicians, doctors and consultants to A&E departments (EDs) in the NHS in the UK and other healthcare systems across the world.

1. What are the main challenges facing emergency health services in the UK? How are these challenges affecting service users?

Crowding in Emergency Departments



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The Urgent and Emergency Care (UEC) system supports a significant number of patients with a huge variety of medical conditions and social problems, ranging from acute emergencies and trauma to acute mental health crises, and the care of homeless, and elderly patients. EDs are by their nature dynamic, providing responsive care to those who need it and an essential front-line service available 24 hours a day, seven days a week. Very few people plan to visit an ED, yet everyone is a potential patient.

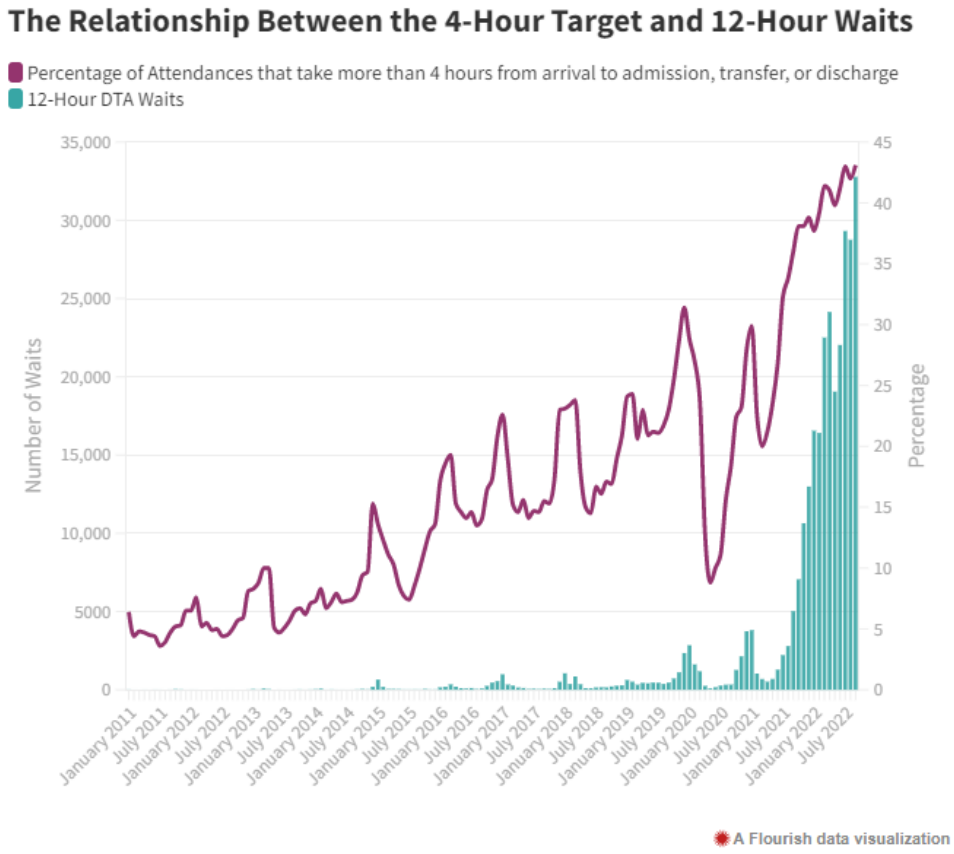
Emergency Departments (EDs) across the UK are dangerously crowded. This represents a major threat to public health and requires a serious policy challenge that must be implemented urgently. Although crowding is present in health systems across the globe, it has worsened significantly in recent years in the UK due to the severe mismatch between demand and capacity in the NHS. Crowding occurs because an acute hospital does not have enough beds to admit their patients. The gradual loss of acute beds within hospitals is a key contributing factor: since 2010, over 29,000 hospital beds have been removed from the system, despite no reduction in demand. The UK has one of the lowest numbers of beds per capita in comparison to OECD nations. In England, in September 2022, there were 96,668 general beds, and the bed occupancy rate was 93.6%, 0.8 percentage points higher than the previous month, and the highest monthly figure on record (since monthly records began in March 2020). The occupancy rate for adult general and acute beds stood at 95.1%, also the highest figure on record.

The significant lack of social care further exacerbates this and is the primary contributor to delayed discharges. These usually occur when patients are medically fit to leave the hospital but are unable to do so due to a lack of social care packages which are often not immediately available. As such, they remain in their hospital bed, meaning patients awaiting admission into a bed are unable to move onto the next stage of their care.

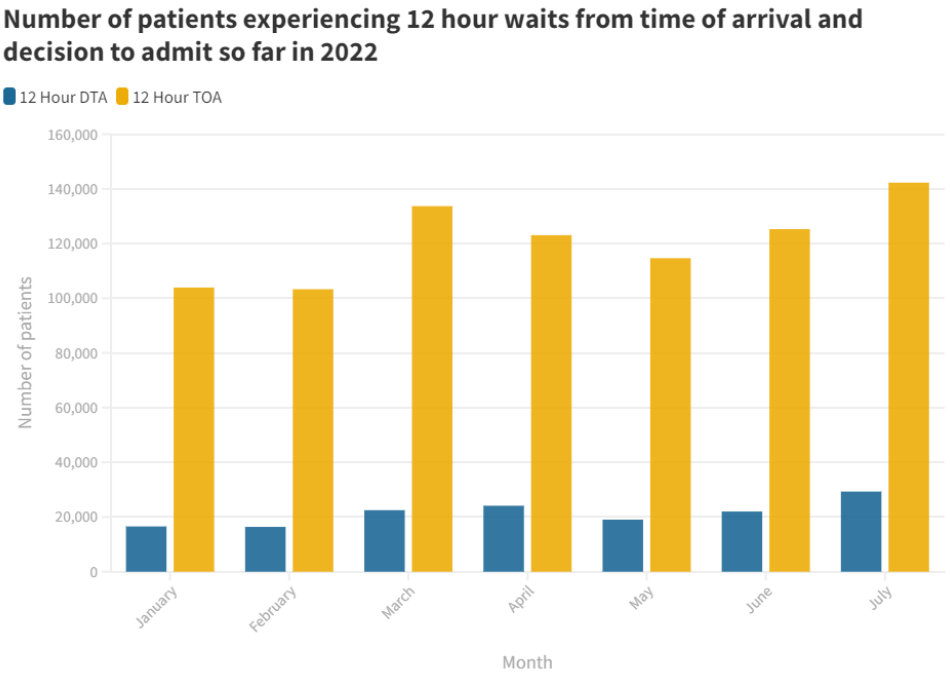
Recommendation: to drive meaningful change in the NHS an additional 4,500 staffed General and Acute beds across the United Kingdom must be made available between now and Winter 2022/23, and approximately 8,500 more over the next five years.[2]

Recommendation: Expand social care capacity in order to meet the needs of an ageing and growing population. Discharge to Assess and Home First models must be maintained and expanded to ensure patients are discharged safely and promptly when their hospital care is complete.

[2] https://res.cloudinary.com/studio-republic/images/v1653920684/RCEM-Acute-Insight-Series-Beds-1/RCEM-Acute-Insight-Series-Beds-1.pdf?_i=AA



The deterioration of the four-hour target and the increase in the 12-hour 'decision to admit' (DTA) stays shows that poor patient flow through the hospital is a problem. In September 2022, only 56.9% of patients were admitted, transferred, or discharged within four hours from arrival – this is the lowest figure on record. Similarly, four-hour performance has hit record lows in the devolved nations. During August 2022 only 55.8% of patients were admitted, transferred or discharged within 4 hours in Welsh Type 1 EDs and in Scotland, this figure stood at 66.10%.



In September 2022, the number of patients staying more than 12 hours from the decision to admit to admission stood at 32,776, this is the highest figure on record, 552% higher than September 2021, and 7056% higher than September 2019. There have now been 211,542 12-hour stays recorded so far in 2022, 2.6 times as many as were recorded in the 137 months prior to 2022 combined. However, we have long argued this metric is misleading and only represents the tip of iceberg in terms of delays to treatment; this metric should be recorded from the moment the patient steps foot into the ED not from the decision to admit them. The graph above reveals the huge discrepancy between the published number of patients staying 12 hours or more from decision to admit and the number of patients staying 12 hours or more from their time of arrival into the ED. The time of arrival figures are recorded by NHS England but are not published monthly.

Consequences of crowding on patients

Crowding results in long stays to be seen, breakdown of departmental processes, patients waiting or being treated in non-designated clinical areas such as corridors, and delayed ambulance handovers. When crowding occurs inside the hospital, patients waiting in corridors are likely to outnumber those in cubicles. The longest waits are disproportionately experienced by the sickest and most vulnerable patients who may be elderly and experiencing distress. Mental health presentations for EDs have accounted for less than 3% of total attendances in recent months and yet these patients are twice as likely to spend 12 hours in the ED when compared to all attendances. Nearly 12% of all patients with mental health needs spend more than 12 hours in an ED from their time of arrival.[3]

Crowding is not only inhumane and undignified for patients, but also dangerous. Studies show that patient mortality increases when there are long delays to admission. Data in the Getting it Right First Time (GIRFT) Emergency Medicine report showed an increase in the Standardised Mortality Ratio (SMR) associated with ED delays beyond 5-6 hours from time of arrival. Their logistic regression model found that of those patients delayed by 8-12 hours in the ED, there was an associated 30-day mortality rate for 1 in every 72 patients.[4] No patient should ever come to unnecessary and preventable harm yet given the extent of long stay in our emergency departments, we know that this is happening on a daily basis.

Impact on the ambulance service

Another consequence of crowding is the impact it has on the ambulance service. When EDs are stretched beyond their capacity, they are no longer able to accept patients who arrive by ambulance, and the ambulances containing these patients are forced to wait outside. Winter 2021/22 UEC situation reports reveal poor weekly performance over an 18-week period demonstrating a lack of system resilience and capacity to weather winter pressures. This reporting period saw a total of 1,503,065 ambulance arrivals, 6.2% less than in winter 2020/21. Despite a lower number of patients arriving by ambulance, this winter a total of 324,486 ambulances experienced delays of 30 minutes or more, 89.8% more than the previous year. From 29th November 2021- 3rd April 2022 an average of 21.6% of ambulances were delayed by more than 30 minutes, and an average of 8.9% were delayed by more than 60 minutes. The detrimental effects that crowding can have within the department is well established, but patients staying in ambulances are likely to suffer the same harm from their waits as patients receiving care in corridors. Additionally, when ambulances cannot offload patients into the department in a timely manner, they are unable to return to the community where patients

[3] https://rcem.ac.uk/wp-content/uploads/2022/09/RCEM-Acute-Insight-Series-Mental-Health-Emergency-Care.pdf

[4] https://www.gettingitrightfirsttime.co.uk/medical-specialties/emergency-medicine/

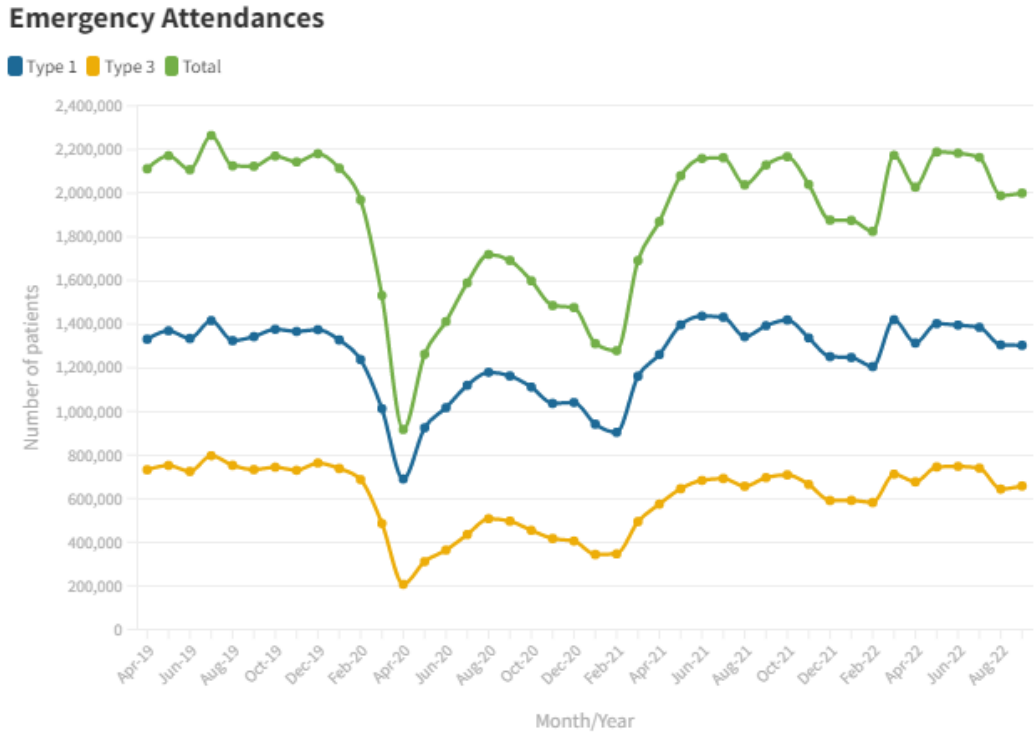
may be waiting for emergency care. Two patients are at risk for every ambulance unable to offload: the patient in the ambulance and a further patient waiting for an ambulance.

Impact on Emergency Medicine professionals

An overwhelmed UEC system places additional strains on emergency care professionals who were already prone to burnout and moral injury prior to the pandemic. Unfortunately, this contributes to the loss of highly skilled emergency care clinicians. An overwhelmed system marked by high levels of crowding may increase the risk of significant adverse events, errors, complaints, and litigation - which come with associated negative effects on staff. In our Retain, Recruit, Recover (2021) report we found that half of respondents are considering reducing their working hours, while just over a quarter are considering taking a career break or sabbatical. When asked what prompted them to make this decision, 32% selected workload pressures and 35% selected burnout.[5] While these clinicians are only considering changing their working patterns, attrition of this nature contributes to shortages of highly skilled staff, and a vicious cycle can develop as the remaining staff suffer from increased stress and hence a greater chance of burnout.

Recommendation: Governments must act now to achieve safe staffing levels in EDs. There is a shortfall of 2,000-2,500 Whole Time Equivalent Emergency Medicine consultants in the UK. Expansion of the workforce is needed to ensure patients are treated by staff who are trained in Emergency Medicine.[6]

2. How have the type, and volume of demand for emergency services changed over recent years?



ED attendances

ED attendances can provide useful measures of overall demand for emergency care. The graph above shows attendances to type 1 (24-hour consultant-led departments) and type 3

[5] https://rcem.ac.uk/wp-content/uploads/2021/10/Retain_Recruit_Recover.pd

[6] https://res.cloudinary.com/studio-republic/images/v1634809665/Retain_Recruit_Recover/Retain_Recruit_Recover.pdf?_i=AA

(minor injury units) departments from April 2019 to August 2022. The three dips in attendances correspond to three major waves of coronavirus in England. Additionally, the graph shows that attendances to type 3 services remain below pre-pandemic levels and attendances to all forms of emergency service have remained fairly static over the past few months. In September 2022, there were 1,302,577 type 1 attendances at EDs. This represents a 6.0% decrease compared with September 2021, and a 5.8% decrease compared with pre-pandemic levels (September 2019).

Demand and social deprivation

The GIRFT Emergency Medicine (2021) study highlighted that deprivation is the single most important factor in ED demand.[7] For example, 2021/22 HES data revealed attendance rates in the most deprived areas of England were almost double the attendance rates in the least deprived areas.[8] These areas additionally have poor provision of primary and preventative care, resulting in EDs sustaining other parts of the health and social care service. EDs additionally serve vulnerable populations. For example, homeless people in England use Emergency Departments 5-7 times more than the general population and are admitted to hospitals four times as often.[9] Furthermore, people who are homeless stay three times longer than the general population. In 2019 the BMA reported that the number of visits to EDs by homeless people almost trebled in the last 7 years.[10] The cost-of-living crisis may increase presentations to EDs this winter. As more of the population plummets into social crisis, this may well have an impact on number and type of attendances we will see this winter, particularly in poorer areas of the country.

Mental Health attendances

Mental health attendances to the ED identified in Hospital Episode Statistics rose by 133% between 2009/10 and 2018/19. Some of this increase may be attributable to improvements in clinical coding, and improvements in recording information about patient journeys. However, the Emergency Care Dataset revealed that mental health ED attendances have not increased at the rate previously illustrated by Hospital Episode Statistics. Since April 2021, mental health attendances have accounted for less than 3% of total attendances to EDs.[11]

From 2009/10 to 2018/19 the numbers of under 18s attending EDs rose to 341%. In 2009/10, 6.9% of all mental health ED attendances were children and young people under the age of 18 (6,192 individuals). In 2018/19, 10% of all ED mental health attendances were under 18s. This means that in 2018/19, 26,582 children and young people experienced a mental health emergency so severe that it resulted in them needing to attend an ED.[12] Some of this increase may be due to an improvement in coding, but this increase aligns with RCEM members experience and accounts during this time.

Emergency admissions

An emergency admission is one where a patient is admitted to hospital urgently and unexpectedly (i.e., the admission is unplanned). Emergency admissions often occur via the

[7] https://www.gettingitrightfirsttime.co.uk/medical-specialties/emergency-medicine/

[8] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2021-22

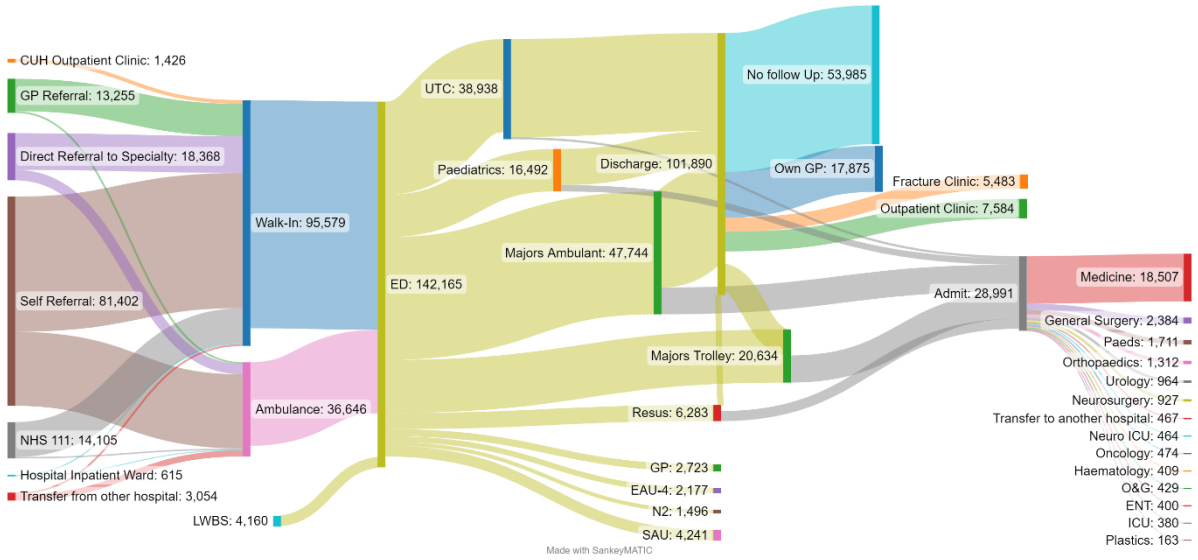
[9] Office of the Chief Analyst. Healthcare for Single Homeless People. London: Department of Health, 2010; NHS North West London. Rough Sleepers: Health and Healthcare. London: NHS North West London, 2013.

[10] Iacobucci Gareth. Homeless people's A&E visits treble in seven years BMJ 2019; 364 :l323

[11] https://rcem.ac.uk/wp-content/uploads/2022/09/RCEM-Acute-Insight-Series-Mental-Health-Emergency-Care.pdf

[12] https://rcem.ac.uk/wp-content/uploads/2022/09/RCEM-Acute-Insight-Series-Mental-Health-Emergency-Care.pdf

ED but can also occur directly via GPs or consultants in ambulatory clinics. There has been a steady and significant increase in both the numbers of total emergency admissions per year and the proportion of these admissions from the ED. In 2021, 30% of type 1 attendances were admitted into hospital, compared to 25.6% in 2011. This means that not only are more people presenting to EDs requiring admission, but the patients also have more severe and complex needs.



The Sankey chart above demonstrates the nature of emergency care demand, and how demand relates to admission, transfer and discharge between different aspects of the healthcare system. The 'majors ambulant' patient represents the largest patient group in any ED. This shows that the demand from lower acuity patients that could perhaps been seen elsewhere is not what is primarily contributing to crowded departments. The reality is much more complex. Demand management interventions are poorly evaluated and there is a lack of evidence to suggest that they help to tackle the problems associated with poor patient flow. RCEM cautions against significant investment into this area.

3. Where and when should decisions of whether someone should receive an emergency health response be made? Who should be making those decisions?

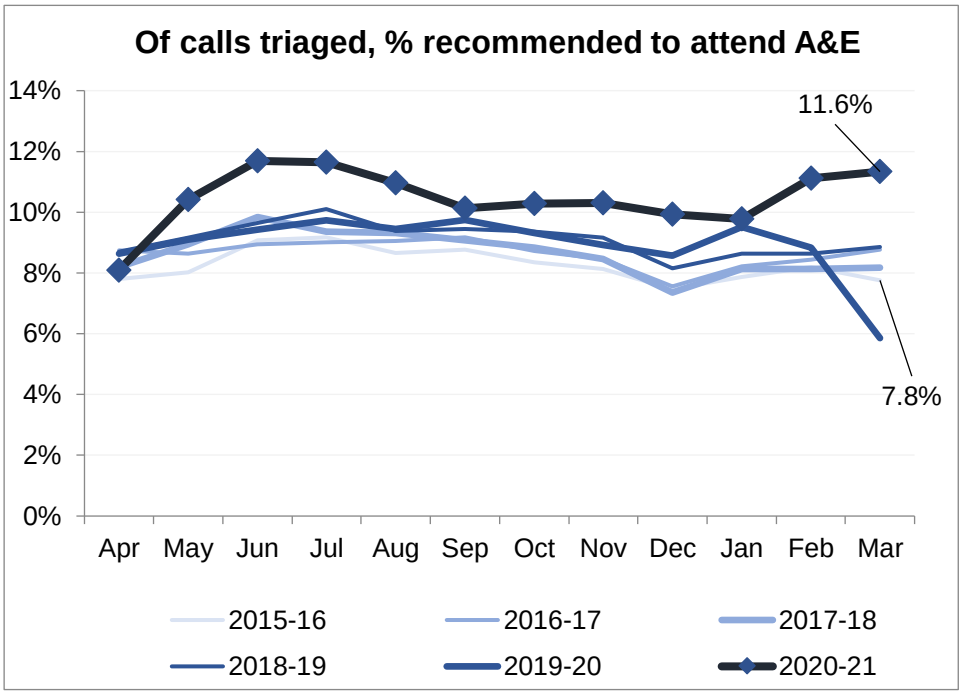
<u>NHS 111</u>

Calls to the NHS 111 service are managed by non-clinical trained 'health advisors' who refer patients onto relevant services based on the needs identified on the call. Health advisors should have access to clinicians who can provide advice and guidance.

NHS 111 has sought to provide patients with the opportunity to seek medical advice over the phone or online and then assist them by directing callers to the most appropriate care. However, if alternative services to the ED are not available, the algorithm will direct patients to EDs regardless of whether it is the most appropriate place for them or not. For example, the CQC's State of Care 2021/22 report found that in the healthcare systems inspected, high demands on urgent and emergency care services were exacerbated by people's inability to access primary care services as a first port of call. NHS 111 was experiencing high call volumes, along with staff shortages. For example, ED dispositions for NHS 111 calls has increased from 8% to 14% during 2022 and in hours calls have increased by 70% since 2020,

reflecting a lack of access to primary care. In their inspection reports, the CQC found that this caused delays in giving clinical advice, and high call abandonment rates may have led to people going to A&E instead. The lack of available GP and dental appointments meant that NHS 111 could not always appropriately signpost people to primary care, resulting in directing people to call 999 or to present at the Emergency Department.

These issues are further exacerbated by a lack of clinical validation within NHS 111. The proportion of calls that are 'clinically validated' must be significantly increased by recruiting more clinicians to work for NHS 111. This would result in an increased proportion of patients being directed to settings other than EDs for their healthcare needs to be addressed. These settings might include primary care, pharmacy services, hospital home-type schemes, other community services, SDEC (same day emergency care) units, hot clinics, urgent treatment centres, and district nursing. CQC's State of Care report inspected systems that saw NHS 111 services making additional use of midwives, mental health practitioners and pharmacists. By providing access to a wide range of healthcare professionals, they could give more appropriate clinical advice to people accessing NHS 111 and support local systems to provide alternative provision to the ED.



The graph above demonstrates that since 2015/16 the percentage of calls recommended to attend an emergency department has increased. In 2021/22, 50.9% of calls were assessed by a clinician or clinical advisor and 11.6% directed to ED. Anecdotally, we know that the Welsh NHS 111 service has greater clinical involvement and as a result is able to provide a more responsive service to its patients.

A recent review of the NHS 111 service during the pandemic carried out by the Healthcare Investigation Safety Branch recommended that NHS England reviews the risks associated with increased use of telephone triage in response to national healthcare emergencies. Consideration should be given to applying any recommendations of this review across telephone triage services within the wider healthcare setting.[13]

[13] https://www.hsib.org.uk/investigations-and-reports/response-of-nhs-111-to-the-covid-19-pandemic/

4. How far are the targets set for emergency health services helpful for driving good practice and processes which benefit service users?

Due to the uncertainty around the future of the four-hour standard and the Clinical Review of Standards (CRS), the UEC system in England has been operating in a performance vacuum. The Royal College of Emergency Medicine engaged in the CRS process to support the delivery of high-quality care and ensure that the metrics supported good patient flow throughout hospitals.

NHS England selected fourteen pilot sites to implement several alternate metrics. The College worked closely with NHS England to develop a bundle of metrics that was put to a public consultation in December 2020. This bundle covers the full patient journey but recognises the different needs of admitted and discharged patients by disaggregation of the metrics. However, there has been a lack of transparency about the data and no consistent instructions to the pilot sites about how to implement the proposed framework.

The four-hour access standard has been deprioritised across the fourteen pilot sites and due to the uncertainty around the future of the four-hour standard and the CRS, the UEC system across England has been operating in a performance vacuum. There is a lack of accountability for UEC performance, as NHS Trusts are not sure what metrics to focus on. RCEM has always maintained that the four-hour standard should not be replaced unless there was significant evidence base supporting its replacement.

It is also important to state that metrics alone do not drive improvements in the UEC system, it is the culture of commitment to value and meet the metrics that makes the difference. One of the most important metrics in this bundle measures the number of patients who have been waiting in EDs for twelve hours or more from their time of arrival. This is a simpler, patient-centred measure, which brings performance measurement in England in line with the rest of the devolved nations.

The Royal College of Emergency Medicine has long argued that the current way in which the 12-hour metric is measured and published – from the decision to admit (DTA) – is misleading and conceals the sheer numbers of patients who suffer very long stays in Emergency Departments. Publication of the 12-hour data from time of arrival will bring about greater accountability in the entire health and social care system. This will help us, NHS England, Trusts, and Integrated Care Systems to better understand the extent of crowding, long stays and corridor care taking place in our Emergency Departments. Better quality data will help to inform policymakers and allow us to make the case for corrective investment into the NHS. Transparent public scrutiny of the number patients staying over 12 hours will drive policymakers and system leaders to take action.

Recommendation: NHS England must publish the number of patients staying 12 hours or more from their time of arrival. This data must be published immediately on a monthly basis so patients and policymakers can understand the true extent of crowding and corridor care.

What impact do regulations and inspections have on decision-making in and for emergency services?

Regulations and inspections have minimal impact due to a general lack of accountability. Unfortunately, the regulatory environment is not supporting performance of the Urgent and Emergency Care system: for example, in 2022 the NHS Benchmarking service reported that just under half of EDs within their sample (48.3%) recently received a CQC rating of 'inadequate' and 'requires improvement'. There have been a number of studies assessing the impact of the regulatory regime on ED performance. One examined the CQC ratings of EDs of 118 hospitals in England between 2013 and 2016 and found they were not associated with

their performance on six emergency care quality indicators prior to inspection.[14] Nor did the performance on these indicators change after inspection. Research has indicated that with the emergency care performance management regime carried out by NHS England and external factors such as pressures on hospitals may override the regulatory regime's ability to generate improvement.[15]

In the 1990s there was a national drive to 'end inappropriate trolley waits for assessment and admission'.[16] These waits were called 'trolley waits' as they are made up of patients waiting to be admitted to wards, often on trolleys. It is well established that waiting on trolleys or in corridors can lead to suboptimal standards of care, putting patients at risk. In 1999 the then Government established an "accident and emergency modernisation programme" informally dubbed as the "trolley task force".[17] The national ambition was to ensure no patient experienced unnecessary delay from admission to a hospital bed. As part of this drive, Chief Executives of hospital trusts were given strict instructions over the winter periods regarding the management of trolley waits. Any wait of more than four hours is directly reported to the hospital's Chief Executive and any stay of more than 12 hours is reported to the Regional Director.[18] A senior manager in each hospital has been given personal responsibility for trolley waits. The drive to reduce waiting times had a positive impact, and by 2005 there was a huge reduction in waiting times in the UEC system. This line of accountability is no longer intact and given the number of long waits we are witnessing, would no longer be practical or possible. However, there is a desperate need for accountability and a driving force for change; it should not solely fall to the clinicians working tirelessly on the ground, to advocate for patients.

How would you describe the UK's emergency service model, and decision-making and planning processes? How could they be improved to secure better outcomes for patients?

<u>Integration</u>

There are unfortunately few examples of good integration across parts of the NHS Urgent and Emergency care system. The siloed nature of UEC means that it is difficult for system leaders to identify and share risk equitably across the system. Integration is crucial in enabling frontline workers to make decisions on emergency care and ensuring continuity of care across the entire health and social care system. For example, the lack of integration between social care and secondary care means that some patients may be medically fit to leave but need help to recover in the form of a social care package. If this is not available, they end up staying in hospital longer than necessary. Additionally, there is a need for integrated ICT systems across the NHS: it is not routine for EDs to have access to a patient's GP records which can unnecessarily slow down care. Cambridgeshire and Peterborough NHS Foundation Trust invested in the EPIC ICT system which meant that clinicians working in the Trust could access a patient's medical records within a single ICT system.

The importance of whole system integration should not be underestimated. When the infrastructure for directing patients from primary care to the next stage of their care are compromised or simply do not exist, the ED becomes the default holding area. These patients, requiring specialist care, will then become the responsibility of the emergency department until

[14] https://emj.bmj.com/content/emermed/36/6/326.full.pdf

[15] https://www.research.manchester.ac.uk/portal/files/77461382/cqc_provider_performance_report_september2018.pdf

[16] HMSO (2000) The NHS Plan. A Plan for Investment. A Plan for Reform. Available here.

[17] Hansard (2022) "Trolley Task Force: Volume 345: debated Tuesday 29 February 2000. Available here

[18] https://hansard.parliament.uk/Commons/2000-02-29/debates/9a87c747-2d15-4a10-a6b2-c1e5751b2095/TrolleyTaskForce?highlight=trolley%20wait

they can be seen by the appropriate specialty. Furthermore, due to the working day, if patients arrive at hospital in the evening when many support services are not available, this can result in admission or a further visit the next day for a patient.

The best outcomes are achieved when patients have access to appropriate, well-resourced health and care system that can deliver timely and high-quality care for all patients. At present, service availability defines the UEC system, rather than population health needs. Integrated Care Systems are best placed to ensure that primary, secondary, and social care are integrated and coordinated to provide patients with a seamless service that meets their clinical needs.

Examples of good practice

Liaison Psychiatry

Liaison Psychiatry Liaison psychiatry is a specialty that provides a range of mental health services in physical health settings including mental health care to people with urgent needs arriving to EDs. Working alongside clinicians in EDs, Liaison Psychiatry provides quality of access, clarity of communication and concurrent care, supporting vulnerable patients with their mental health needs in acute settings.[19] Core 24 provision describes a service that is available 24 hours a day, seven days of the week. There have been great improvements in the scaling up of Liaison Psychiatry provision in England in recent years: in 2016, only 12% of services provided Core 24 provision in England. Data from 2022 reveals that 64% of hospitals now provide this service.[20] The NHS Long Term Plan outlined a commitment to ensuring 70% of Mental Health Liaison services in acute hospitals met the 'Core 24' standard for adults by 2023/24, working towards 100% coverage thereafter.

NHS England's Interim Report of the Clinical Review of Standards (CRS), published in March 2019, proposed the one-hour referral metric, whereby "patients referred from an ED should have a face-to-face assessment by mental health liaison, or children and young people equivalent service commence within 1 hour."[21] This has yet to be introduced despite being consistently welcomed by every organisation as its use would promote equality and transparency of provision.

Recommendation: The UK Government should continue to invest in Liaison Psychiatry services, to honour the commitment to provide not just minimum Core 24 services but provide enhanced and comprehensive services in bigger NHS Trusts.

Recommendation: NHS England should introduce the one-hour standard to be seen by a Mental Health Professional from referral from ED, for all ages, as recommended in the Clinical Review of Standards.

HIU Right Care

RCEM's report examining Mental Health Emergency Care highlighted that an effective mental healthcare system requires balance between adequately funded community-based services and hospital provision.[22] Integrated Care Systems must play a role in ensuring mental health services are integrated more systematically into the wider healthcare system and to give

[19] 4 RCEM, RCPsych, RCN, RCP (2020) Side by side: A UK-wide consensus statement on working together to help patients with mental health needs in acute hospitals. Available here.
[20] NHS England (2016) Report of the 3rd Annual Survey of Liaison Psychiatry in England. Available here.
[21] NHS England (2021) Mental Health Clinically-Led Review of Standards. Available here.
[22] https://rcem.ac.uk/wp-content/uploads/2022/09/RCEM-Acute-Insight-Series-Mental-Health-Emergency-Care.pdf

better, more coordinated care to people with mental illness. There must also be significant investment and expansion of mental health community care and preventative services in order to ensure patients get the support they need.

Patients are classified as high intensity users (HIU) if they present to the ED five times or more within a year.[23] Of the patients who meet this definition, 71% have a diagnosable mental health problem. The Red Cross reported 16% of ED attendances nationally were by patients attending five times or more in 2020, illustrating a large and increasing group of patients with unmet needs.[24] An ED attendance can meet a patient's immediate UEC needs but cannot make much impact on the overlapping mental health, drug, alcohol, social and chronic physical health problems which need longer term support. Various initiatives such as "HIU Right care", community prescribers and multi-agency working have indicated that tailored care can tackle the underlying mental, physical and social challenges this population face.[25] Unfortunately, evaluation of these interventions has relied on before and after measures rather than a control group. There is a need for robust evaluation of these interventions to better understand their effect.

Recommendation: Integrated Care Systems must prioritise early intervention multidisciplinary services to address the underlying unmet need in High Intensity Use. There should be robust evaluation of services to see which models work best.

Mental Health Joint Response Car

In London Mental Health Joint Response Car launched in November 2018 had a significant positive impact in reducing conveyance rates i.e., the decision to transport a patient to a healthcare facility, with a conveyance rate of only 18% compared to the usual rate of 52%.[26] Integrated Care Systems have the power to play an important coordinating role in providing crisis response services. Additionally, this service can provide advice to police may reduce the use of the Mental Health Act. There must be robust evaluations of these services to determine whether they reduce the use of the Mental Health Act.

Recommendation: Integrated Care Systems must ensure universal coverage of crisis response services in every community. These include ambulance – mental health joint response cars, 24/7 phone lines and crisis cafes.

[23] Designing services for frequent attenders to the Emergency Department: a characterisation of this population to inform service design. Morris et al, Clinical Medicine 2016: 16 (4) 325-9.

[24] https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/exploring-the-high-intensity-use-of-accident-and-emergency-services

[25] https://www.england.nhs.uk/high-intensity-use-programme/

[26] AACE (2020) Mental Health Joint Response Car. Available here.