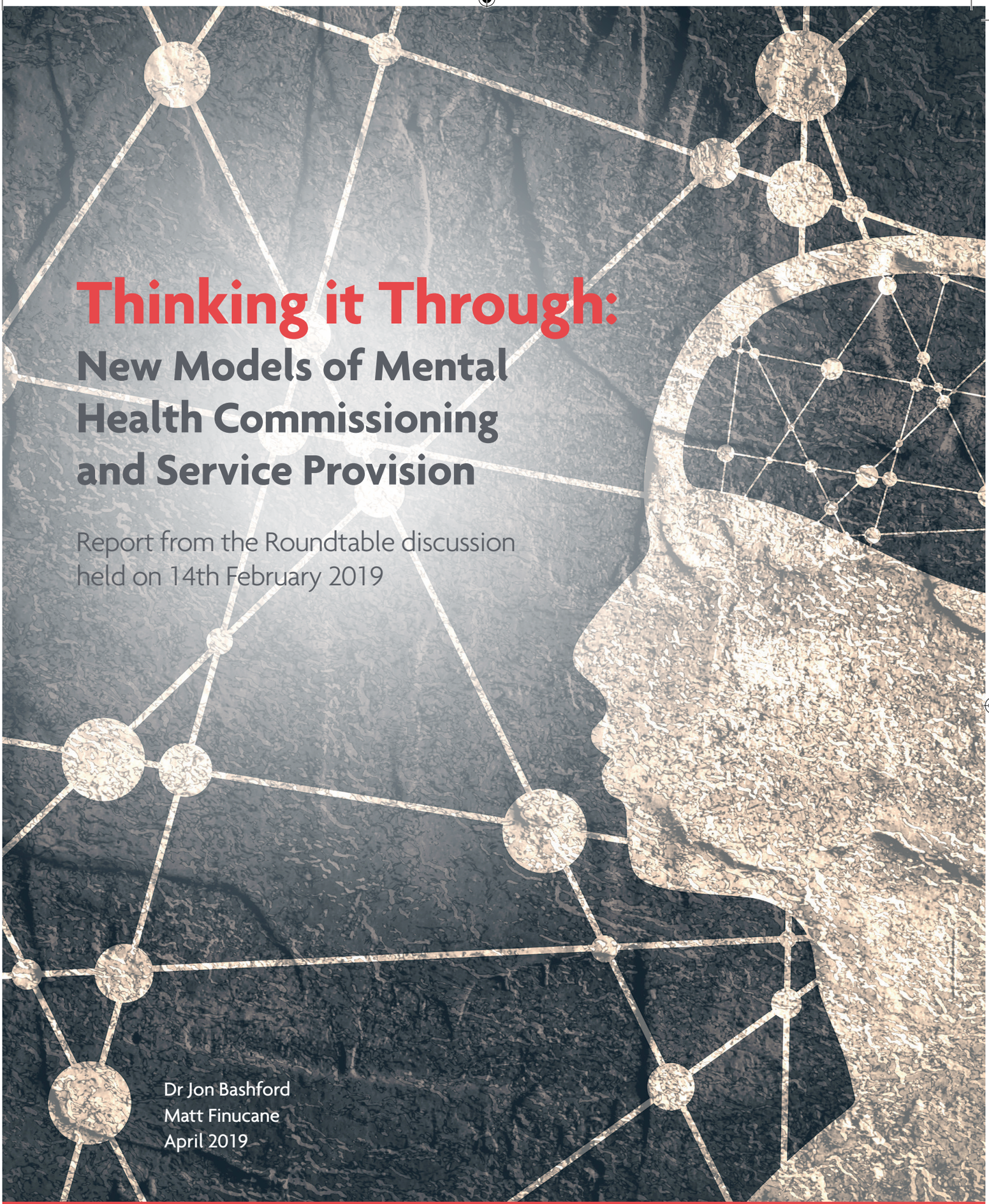

Thinking it Through:

New Models of Mental Health Commissioning and Service Provision

Report from the Roundtable discussion held on 14th February 2019

Dr Jon Bashford
Matt Finucane
April 2019

BREAKING BARRIERS
INNOVATIONS

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Introduction

Thinking it Through is a collaborative programme between Breaking Barriers Innovations (BBI) and partners from the independent sector and the NHS. The purpose of the programme is to assess new approaches to planning and transformation of mental health services, in particular, how to improve delivery in high acuity mental health provision that will:

- support the drive towards parity between physical and mental health care; and
- provide the right balance between meeting the needs of people in mental health crisis, improve prevention and early identification and ensure high quality and sustainable treatment and care planning.

The programme is comprised of an analysis of the current policy and legislative context and drivers for change, alongside exploratory discussions with leading personnel from partner organisations in the NHS, local authorities and the independent sector.

BBI convened a Roundtable on February 14 2019, which was attended by a number of senior managers and leaders from across health and social care commissioning and service delivery. The aim of this Roundtable was to identify the key challenges facing mental health services, how these are being addressed, and what the vision for the future of mental health commissioning and provision looks like, in light of the NHS Long Term Plan (LTP) and the independent review of the Mental Health Act. Four questions were posed to the participants:

- What are the main barriers and challenges in taking forward new models of care and treatment arising from the NHS LTP and the independent review of the Mental Health Act?
- What can be learnt from a focus on place and thinking about vulnerable groups in the system?
- What steps do local areas need to take in the next 12 months to enact changes required under the NHS LTP?
- What additional support is required for local areas to develop a more integrated, place-based local offer for mental health services?

The Roundtable was held as a closed Chatham House discussion and this report seeks to capture the issues that were raised. This includes examples of innovation and best practice, and the main challenges and opportunities that lie ahead over the next twelve months for commissioners and service providers.

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Background: The National Policy and Legislative Context

In January 2017, the Prime Minister made a commitment to giving mental health "the attention it deserves, in funding, research and technology investment". In particular, she stated that when NHS leaders are redesigning services and developing new solutions, mental health should receive full consideration, so that government can transform the way that mental health problems are treated at every stage of a person's life. This commitment should be viewed as part of an increasing focus on, and awareness of, the importance of mental health in recent years and the drive to improve service provision. For example, there are wide local variations in access, waiting times, quality and the range of treatment.

There are also variations in the degree of collaboration and integration between those providing care and support for people with mental health problems, including historically low levels of investment and lack of parity between mental health and physical health. Mental health problems account for 28% of the burden of disease but only 13% of NHS spending, and only 25% of people needing mental health services have access to them (NAO, 2016). In its report to NHS England, *The Five Year Forward View for Mental Health*, the independent Mental Health Taskforce concluded that:

"Years of low prioritisation have led to clinical commissioning groups (CCGs) underinvesting in mental health services relative to physical health services...Spending per capita across CCGs varies almost two-fold in relation to underlying need." (Mental Health Taskforce, 2016)

Against this background there has been a continuing reduction in the number of acute in patient mental health beds and rising numbers of people detained under the Mental Health Act. For example:

- The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012.
- Bed occupancy has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery.
- Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage has led to people being transferred long distances outside of their area.

Access to appropriate care planning and care co-ordination was also found to be lacking in many areas. Of those adults with more severe mental health problems, 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and despite improvements too many people never have access to these interventions.

In its review of crisis care, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Also, one-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care co-ordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months (CQC, 2015).

These variations in investment and prioritisation are reflected in outcomes, for example:

- People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England.
- Less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.
- Between 60-70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services.

Suicide is also rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle-aged men. Suicide is now the leading cause of death for men aged 15-49 years.

Men are three times more likely than women to take their own lives, accounting for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death (Mental Health Taskforce, 2016).

Mental health problems amongst some vulnerable groups are even higher, with poorer access and outcomes, for example:

- Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.
- Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care.
- One in ten children aged 5-16 years has a diagnosable problem, such as conduct disorder, and are 20 times more likely to end up in prison, yet most children and young people get no support.
- One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death after cardiovascular disease.
- One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression (Mental Health Taskforce, 2016).

These outcomes bring into sharp relief the critical conditions that characterise mental health care provision and the urgency behind the drive for improvements and new models of care and commissioning that can adequately meet needs.

The NHS Long Term Plan

The NHS Long Term Plan (LTP) is the latest example of national policy that seeks to strengthen mental health service provision, increase funding and secure parity with physical health. The plan provides a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.In addition, the plan calls for:

- The roll-out of Integrated Care Systems across England by April 2021, bringing together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health and social care.
- A new NHS offer of urgent community response and recovery support – to support patients to navigate the optimal service 'channel', a single multidisciplinary Clinical Assessment Service (CAS) will be embedded within integrated NHS 111, ambulance dispatch, and GP out of hours services from 2019/20 – encompassing both physical and mental health, supported by collaboration plans with all secondary care providers.
- 'shared responsibility for health' – over the next five years the NHS will ramp up support for people to manage their own health. This will start with diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support, and online therapies for common mental health problems. For adults and older people with mental health problems, the LPT states that:
- By 2023/24, an additional 380,000 adults and older adults will be able to access NICE-approved IAPT services.
- By 2023/24, new models of care, underpinned by improved information-sharing, will give 370,000 adults and older adults greater choice and control over their care, and support them to live well in their communities.
- The NHS will ensure that a 24/7 community-based mental health crisis response for adults and older adults is available across England by 2020/21.
- Specific waiting times targets for emergency mental health services will for the first time take effect from 2020.
- Work with those units with a long length of stay will be undertaken to bring the typical length of stay in these units to the national average of 32 days. This will contribute to ending acute out of area placements by 2021.

For children and young people, the LTP states that:

- By 2023/24, at least an additional 345,000 children and young people aged 0-25 years will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams.

- Over the next three years, autism diagnosis will be included alongside work with children and young people's mental health services to test and implement the most effective ways to reduce waiting times for specialist services.
- To move more care to the community, NHS England will support local systems to take greater control over how budgets are managed. Drawing on learning from the New Care Models in tertiary mental health services, local providers will be able to take control of budgets to reduce avoidable admissions, enable shorter lengths of stay and end out of area placements.

The renewed commitment to mental health services, including additional funding to reach parity with physical health has been widely welcomed. However, as the Mental Health Federation states, the additional investment needs to be matched by a commitment on the ground to implement the plan and manage demand realistically and in line with public expectations:

"The extra £20.5bn by 2023/24 promised by the government is a substantial investment. But without a step change in productivity, or in managing demand for care, trade-offs are inevitable. These need to be spelled out clearly so the public know what they can expect from the NHS". (Mental Health Foundation, 2019).

Managing demand is clearly critical to the success of the mental health commitments in the NHS LTP and this will require addressing the shortfalls, capacity constraints and variations in service access and experience. The recent independent review of the Mental Health Act highlights some of the challenges and opportunities that will influence the degree to which local areas can achieve this re-balancing of resources and capacity.

The Independent Review of The Mental Health Act

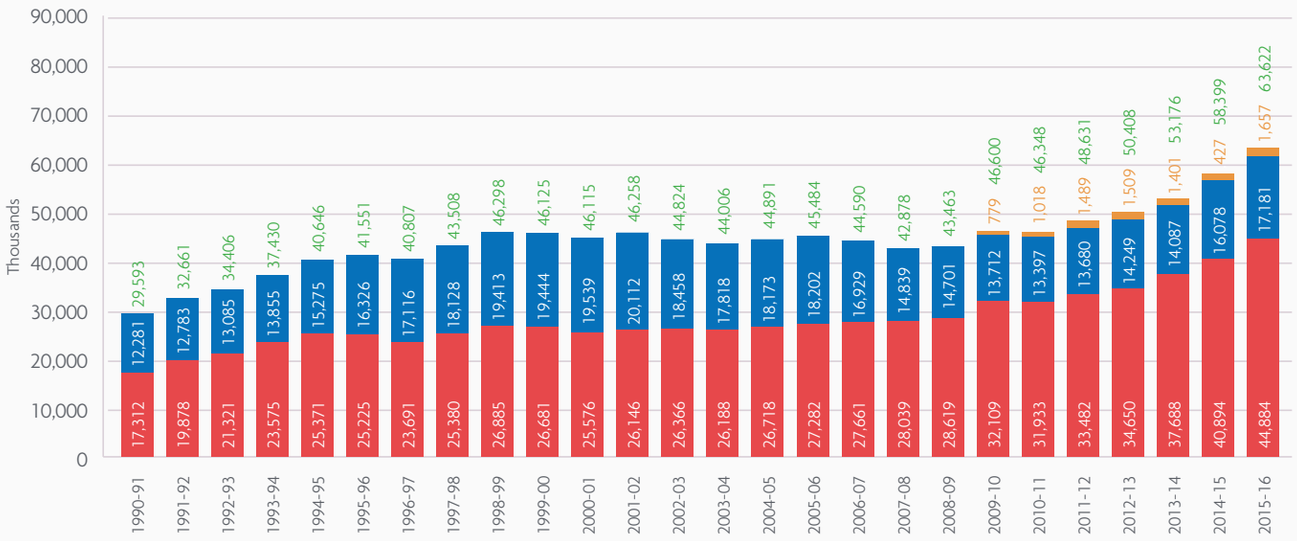
The Independent Review of the Mental Health Act 1983 was set up to increase understating about processes that are out of step with a modern mental health care system, including the reasons for rising rates of detention under the Act, especially the disproportionate number of people from Black and Minority Ethnic groups who are detained.

The final report from the review was published in December 2018 and its recommendations are intended to "shift the dial" in favour of greater respect for the wishes, choices and preferences of people detained under the Act. The review is intended to be read in conjunction with the NHS LTP, and it calls for investment in alternatives to detention and a reinvigoration of community services focussing on a much broader and swifter offer of alternatives to compulsory treatment. In the Foreword to the review, Sir Simon Wesley states:

"We need investment in alternatives to detention, a reinvigoration of our community services focussing on a much broader and swifter offer of alternatives to compulsory treatment." (Department of Health and Social Care, 2018)

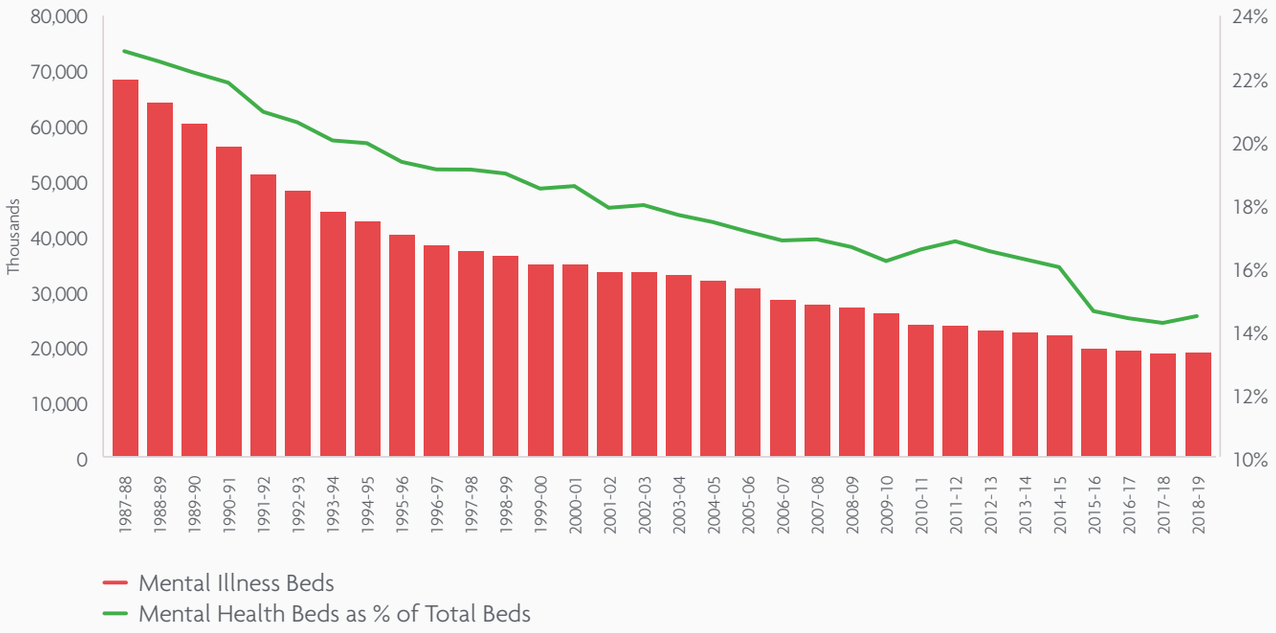
However, offering alternatives to compulsory treatment will not be straightforward as the trend in increased detentions under the Act demonstrates:

Detentions in hospital under the Mental Health Act 1990-91 to 2016-16



This has taken place against long-term trends in reductions of mental health beds, and mental health beds as a proportion of all NHS beds:

Mental Health Beds 1987-88 to 2018-19



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Crisis Intervention and Community Services

The independent review report regards improved access to crisis and community services as key to managing the demand for beds and rising numbers of detention under the Mental Health Act:

"There is consensus that there needs to be both investment and improvement in community mental health services. Services that are disjointed, and under-funded, lead to more people falling through the gaps and ending up in crisis." (Department of Health and Social Care, 2018)

This is something that will need to be considered under the NHS LTP commitments for urgent and crisis care, but also in the forthcoming Green Paper on Social Care, which needs to set out a clear requirement for an integrated approach to crisis provision across health and social care. This may be particularly challenging given the severe cuts to local authority care budgets and increasingly restrictive thresholds for care that many authorities have had to introduce.

An additional challenge identified by the independent review of the Mental Health Act is the trend towards greater risk aversion amongst mental health practitioners. This has been in part fuelled by legal cases that have resulted in a culture of risk aversion and lack of confidence amongst practitioners that they will be adequately supported to raise risk thresholds:

"Professionals need supportive management, training support and supervision from their organisations and encouragement to adopt positive therapeutic risk-taking approaches, in line with the emerging evidence base. To do this will require a concerted, cross-organisation, drive to tackle the culture of risk aversion." (Department of Health and Social Care, 2018)

This is not something that can be achieved by organisations acting alone, and it will require much stronger recognition of the need for system-wide sharing of risk. Establishing an appropriate balance between the need for detention when it is required and having adequate community support is essential. This should include the capacity to manage those individuals that may have some risk, but could be supported in the community with enhanced service provision. However, the review report does not state what this balance might look like in reality and calls for more research into the needs and system level support that is required to enable this:

"Improved research and evaluation is needed to inform the future design, commissioning and funding of services and interventions. This should cover alternatives to detention in inpatient settings, interventions to prevent crisis or the escalation of crisis, and the social factors that lead to crises." (Department of Health and Social Care, 2018)

Although some areas have introduced 24/7 crisis provision, the absence of an appropriate evidence base leaves local commissioners with a dilemma. Do they continue to respond to the increasing calls for enhanced crisis and community care provision by shifting resources from inpatient provision to the community, and if they do so, how will they be confident that the level of inpatient provision is sufficient for the needs? Historically, commissioners have addressed local shortfalls in provision through out of area placements, but these are increasingly viewed as unsustainable and the NHS LTP reiterates the commitment for these to end by 2021.

Out of Area Placements

NHS England's programme for testing New Care Models in tertiary mental health services has been running since April 2017. This programme aims to reduce the length of stay and the number of patients who are out of area in a number of specialised mental health services. It delegates responsibility for the budget for inpatient services to local provider partnerships so they can ensure funding is spent as effectively as possible. Any expenditure gains are retained by the partnerships to invest in improving patient pathways, including in the community. Pilots in this programme:

- use a multi-disciplinary team approach, with providers taking ownership of their patient population;
- develop a wide range of therapeutic interventions across a whole pathway;
- include a focus on recovery through accommodation, community activities, social networks and employment advice;
- work proactively with the criminal justice system, local authorities and secondary care providers;
- expand both liaison support and community follow-up provision; and
- develop local capacity and capability to manage all types of patients.

As at November 2018, 14 partnership sites were live involving a range of NHS Trusts, Clinical Commissioning Groups and independent mental health service providers. Over 257 patients have been brought back into care in their home area during 2017/18. In addition, the average length-of-stay and median distance from home both reduced and this has led to a total saving of £10.7 million, which has been released for reinvestment by provider partnerships in local mental health services.

The latest iteration of the programme is known as Establishing Steady State Commissioning (ESSC), which aims to take the learning from the pilots and make this business as usual. The overall aim of ESSC is to improve outcomes for people using tertiary mental health services, through local management of the whole patient pathway, with incentives for less restrictive and more community-based care. This is to be achieved by:

- Supporting provider-led partnerships to manage budgets, quality and pathways;
- Transitioning the majority of specialised mental health services for the majority of the country by April 2020.
- Maintaining a strategic commissioning role in NHS England with oversight of key areas.
- Organising NHS England nationally to add value and enable straightforward, efficient commissioning.

The NHS LTP states that out of area placements will be ended by 2021.

The independent review of the Mental Health Act report supports ending what it refers to as 'inappropriate' out of area placements, these are those that produce particular hardship for patients and families when the placement is far from the patient's home area. The review also recommends that the CQC should pay particular regard to obtaining patient (and carer) input from those who might find it difficult to articulate their views, including those in secure and out of area placements, those with learning disabilities or autism, children and young people.

Vulnerable Groups

The independent review of the Mental Health Act has a very strong focus on vulnerable groups, in particular, Black, Asian and Minority Ethnic (BAME) individuals who are detained under the Mental Health Act. The report notes that Black African and Caribbean males are significantly more likely to be detained under the Mental health Act and are up to eight times more likely to be subject to a Community Treatment Order.

The report calls for the creation of an Organisational Competency Framework (OCF) to tackle racial disparity. It states that this should have service user and carer accountability measures at its core and be designed to focus on several core competency areas, including awareness, staff capability, behavioural change, data and monitoring, and service development.

The review also calls for stronger systems of advocacy for vulnerable people in the mental health system, especially for those that lack mental capacity. This should be viewed as part of a drive to support more vulnerable people to live independently in the community with higher levels of support and improved risk management in order to support greater independence.

Women and children can be particularly vulnerable to placements in inappropriate inpatient settings, such as on mixed-sex wards for women or adult units for children and young people. Lesbian, Gay, Bisexual and Transgender patients were also reported as being stigmatised and not having their needs addressed. Children and people with learning disabilities and other patients who are vulnerable because of protected characteristics could be more vulnerable to poor care:

"Care and treatment should be tailored with the aim of achieving equality of outcomes across the patient community, regardless of any protected characteristics. Reasonable adjustments should be made where necessary to support this, including those based on the patient's communication abilities and preferences." (Department of Health and Social Care, 2018)

The review holds that good person-centred care is the most effective way to address vulnerability, including caring for people in a way that takes into account the context of 'the communities they come from, their lives and past experiences, including trauma and discrimination'. The independent review calls for an expansion in personalised care, including more gender and trauma-informed services.

System enablers

The independent review concludes by identifying four system-wide enablers:

1. Data

There are flaws in the ways in which data is collected and monitored for the Mental Health Act, both inside and outside the NHS. For example:

- There are several different public sector bodies involved in the MHA, and a number of potential data sources, many of which collects data from different geographical footprints over different timeframes.
- There is no national dataset for the work of Approved Mental Health Practitioners (AMHPs).
- There is no standardisation of ethnic categories across different datasets, so comparison of data by ethnicity is difficult.

The review recommends that NHS England, NHS Improvement, the CQC and NHS Digital, supported by the Department of Health and Social Care, should work together to establish an agreed, accurate national baseline of use of the MHA. In advance of this, pilot areas should be funded to develop a robust methodology, which could then be rolled out nationally.

2. Digital enablers

The review notes that the majority of Mental Health Act related activity is still carried out using paper-based systems, for example, assessment forms, medication or leave forms, or the provision of information about the Act to patients. Digital enablers could provide patients with a modern and consistent way to access information about the Act, their rights, safeguards and treatment processes:

"As well as reducing delays (including during the assessment process), the availability of real-time information and digitisation could maximise the time professionals can spend with their patients. Clinicians and patients could also have access to care records, care plans, treatment preferences and advance choice documents (ACDs), and the details and wishes of nominated persons." (Department of Health and Social Care, 2018)

The review recommends that NHS England should build on the work of the Mental Health Trust Global Digital Exemplars and other Trusts to test, evaluate and roll-out a fully digitised, consistent approach to the MHA supported by relevant changes to the Act and Code of Practice.

3. Quality improvements and monitoring

The review report states that clinicians, ward staff and people with lived experience should be empowered to take ownership of, and benefit from positive change, through improving people's experiences of assessment and detentions under the Mental Health Act.

In order to support this, it recommends the establishment of a National Quality Improvement for Mental Health that focuses specifically on Mental Health Act processes. In particular, the review recommends that national NHS and local authority bodies should explore how a new approach could be replicated locally, including establishing a leadership programme for service users and carers so they feel supported, trained and able to contribute fully to local improvement efforts.

4. Staffing

The review calls for staff members who are working in mental health care, and particularly on inpatient wards, to have the right experience and training, with an understanding of the Act, the new principles and the Code of Practice and knowledge of the rights of patients detained under the Act.

In particular, the review recommends that there should be updated guidance on the appropriate number of AMHPs for the successful operation of the Mental Health Act. This be agreed by a range of stakeholders and professional groups including:

- the Local Government Association;
- the Association of Directors of Adult Social Services;
- the Approved Mental Health Practitioner (AMHP) leads network;
- NHS England;
- Health Education England; and
- the Department of Health and Social Care.

This degree of collaboration on the updated guidance should ensure that the role of AMHPs is adequately supported as part of local integrated care systems.

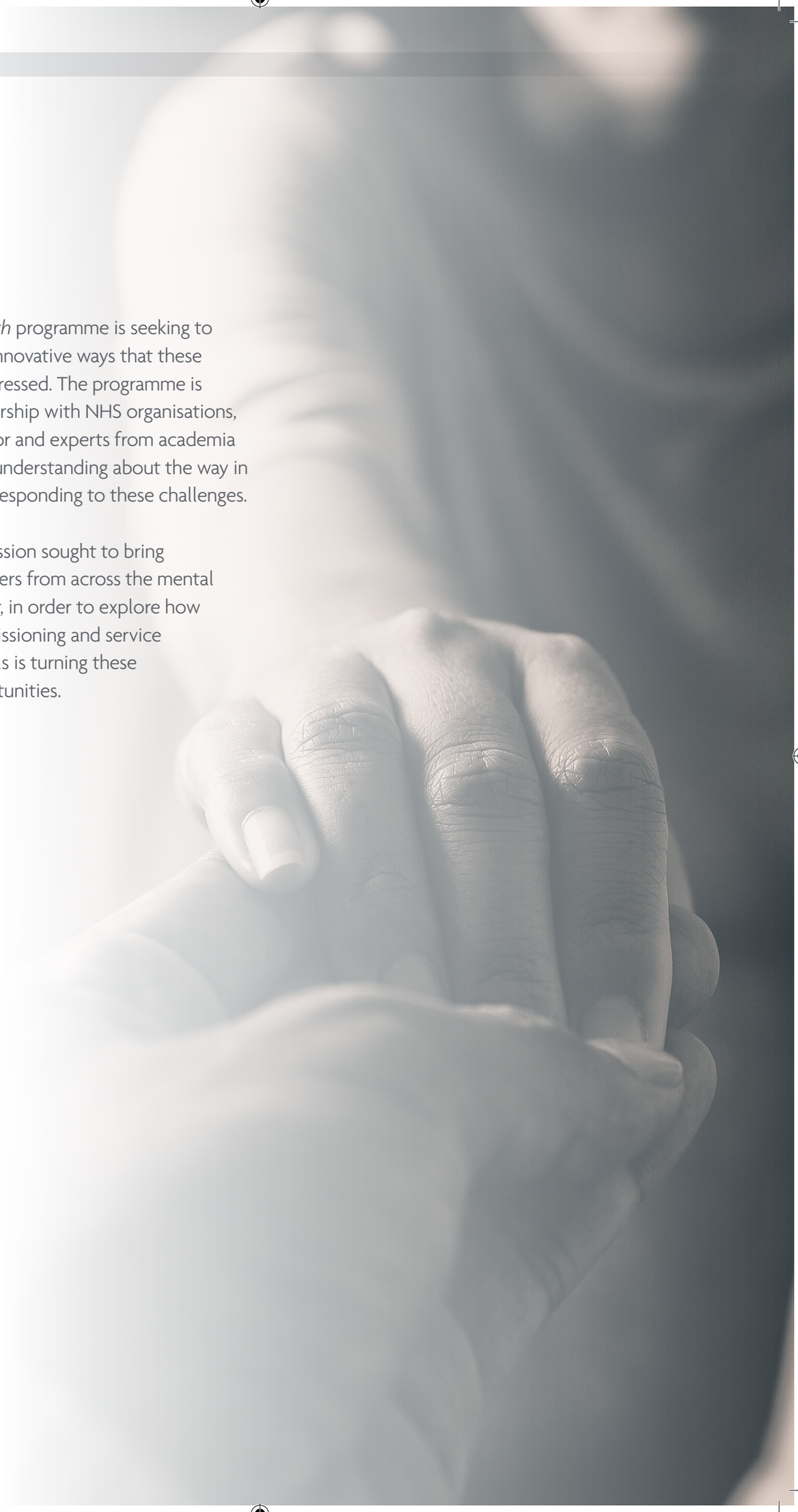
Summary

The NHS LTP and the independent review of the Mental Health Act provide much-needed emphasis and increased priority for mental health service provision, including greater investment and a stronger focus on vulnerable groups. But while this is very much to be welcomed there remain some significant challenges:

- the trend towards fewer acute psychiatric beds and shorter lengths of stay will continue, but there is a need in many areas for a radical increase in community and crisis/urgent care provision to keep people safe and prevent harm;
- there is a need for more targeted provision for some service user and population groups – for example veterans, BAME – where these user/population groups are known to experience unwarranted variations in access, experience of care and outcomes;
- New Models of Care in tertiary mental health services are demonstrating success in reducing the numbers of patients that can be repatriated from out of area placements, however, the pace and scale of this change needs to be matched with local plans for transformation of the acute/community care balance and service mix; and
- safe and effective management of individuals with high levels of acuity in community settings, requires stronger governance with respect to assessment and identification of vulnerabilities and shared risks and accountability frameworks across services and sectors.

The *Thinking it Through* programme is seeking to provide insights into innovative ways that these challenges can be addressed. The programme is building on the partnership with NHS organisations, the independent sector and experts from academia and policy to further understanding about the way in which local areas are responding to these challenges.

The Roundtable discussion sought to bring experts and practitioners from across the mental health sector together, in order to explore how new models of commissioning and service provision at local levels is turning these challenges into opportunities.



The Roundtable Discussion

The Roundtable discussion took place on 14 February 2019 in London. Participants from a range of mental health providers and commissioners took part, including:

Tees, Esk & Wear Valleys NHS FT
NHS Hounslow CCG
NHS City & Hackney CCG
Barnet, Enfield and Haringey Mental Health NHS Trust
Universal Health Services
NHS Hillingdon CCG
Solent NHS Trust
University of Southampton
Royal Hospital Chelsea
Cygnet Healthcare
NHS England
NHS Luton CCG
NHS Central London CCG

The Roundtable was conducted under the Chatham House rule, therefore, quotations from individual participants are provided anonymously. Quotations are only used where these illustrate a common theme or experience amongst the participants.

Barriers and Challenges in Taking Forward New Models of Care and Treatment

Shared Systems of Accountability

Participants identified shared systems for accountability as one of the main challenges in taking forward new models of care and treatment. For example, the ability of commissioners and providers to work collaboratively, alongside service users, in designing and delivering an integrated network of services that can respond to variations in need and acuity. This is not an impossible challenge to overcome and some participants described ways in which they have done this, some of which focused on building the right culture and relationships and others through the use of external, dedicated funding:

"There was a long-term investment in relationships to make the collaboration happen."

"We were fortunate to attract some innovation funding to enable us to re-imagine our mental health programmes using a design thinking approach."

Some of the barriers cited by participants included the length of time it takes to create meaningful change and organisational cultures that can act against greater collaboration:

"Organisational differences, sovereignty, are still holding integration back."

Some participants also questioned how professional accountabilities under new models of care would operate:

"Who is responsible? Who is the lead co-ordinator or navigator for the new ways of working? The Long Term Plan does not provide clarity on this."

But for some participants, creating a culture of shared accountability requires challenging the idea of a lead accountable officer:

"Why have a clinical responsible officer? Risk and accountability shouldn't be owned by the CCG or the provider, you get collaboration by sharing accountability and decision-making."

Where this has been achieved, participants stated that there has to be joint decision-making about resources between commissioners and providers, to the point that *'it is hard to tell who is a commissioner and who is a provider.'*

This creates a serious challenge to the long-term ethos of the commissioner/provider split and goes to the heart of current calls in national policy direction for fresh legislation that can support local integration. This is echoed by the NHS LTP, which calls for primary legislation to strengthen local integration and accountability:

"... amendment to the primary legislation would significantly accelerate progress on service integration, on administrative efficiency, and on public accountability. We recommend changes to create publicly accountable integrated care locally; to streamline the national administrative structures of the NHS; and remove the overly rigid competition and procurement regime applied to the NHS." (NHSE, 2019)

In the words of one participant at the Roundtable:

"The NHS Long Term Plan is about doing things differently, not what we have always done."

In the absence of primary legislation, the challenge for local areas is how to reconcile the competing demands for accountability, both organisationally and individually for practitioners. This requires a new language, whereby commissioners and providers regard themselves as people who plan and deliver as opposed to commissioning and providing:

"We need to become organisationally blind."

Long-Term Rehabilitation and Out of Area Placements

For some participants the culture of mental health service provision has been cyclical. For example, having disestablished the old-style mental health asylums under community care, which was viewed as the right thing to do at the time, recent years have seen a return to providing asylums:

"We had the same discussions in 1995; we said we would shut the asylums and put people in the community; it wasn't a disaster but the level of community support was not sufficient so we started creating new asylums but we called it long-term rehabilitation."

Mental health rehabilitation services are designed to manage care for people with complex psychosis and other conditions. According to the CQC, 80% of people who are referred to inpatient rehabilitation services come from an acute inpatient ward and 20% from secure mental health services. Over half the rehabilitation units in England are provided by the independent sector *'due to a lack of local NHS provision.'* (CQC, 2019).

The perception is that much of this rehabilitation provision, although created due to a lack of local capacity, is dominated by out of area placements, which result in social dislocation. Since the advent of the Mental Health Five Year View and reiterated in the NHS LTP, the drive is for an end to out of area placements so that people can receive the care they need in their local areas. Establishing Steady State Commissioning (ESSC) is the principal model for this shift in provision and participants reported that this is working in some areas, but only where there is a strong commitment to working in collaboration with all regional providers, including the independent sector:

"We see a lot of variations around the country on new models of care for ending out of areas placements. Where the independent sector is embraced as part of the solution this is working well, but there has to be a genuine commitment to breaking down organisational barriers."

For some participants, the target in the NHS LTP to end all out of area placements by 2021 is viewed as a significant challenge that will require not only stronger collaboration between agencies and across sectors, but new ways of addressing the requirements for longer lengths of stay in hospital units:

"The challenge is how to get people off the acute wards when they need longer lengths of stay, we need to unblock this."

The CQC reports that 70% of patients will achieve successful community discharge within 18 months of admission to an inpatient rehabilitation unit. At five-year follow-up:

- 67% will still be living successfully in the community; including:
  - 40% who will have moved on to less supported accommodation;
  - 10% who will be managing an independent tenancy.

  (CQC, 2019)

What these figures do not reveal is the degree and type of support that is required to enable people to remain in the community, nor does it address the demand for re-admission during a person's rehabilitation journey. For participants, understanding the latter is key to new models of care and in particular, whether the focus is on length of stay in hospital or length of time someone manages to live in the community:

"The focus should be on how long someone spends in the community, not on how long they spend in hospital. Frequent re-admissions may not be bad for someone if it means that they spend more time in the community."

This is a much more challenging notion than may appear, as it goes to the heart of the nature of inpatient provision for mental health, and in particular the concept of rehabilitation. The NHS LTP calls for the average length of stay in acute mental health units to be brought down to the national average of 32 days. This is viewed as an important step in reducing the demand for out of areas placements as it is regarded as a means to manage capacity in local units.

However, as pointed out by the independent review of the Mental Health Act, this will not be achieved without sufficient capital investment to ensure that the physical environments of inpatient services can be upgraded to meet the increased demand:

"The government and the NHS should commit in the forthcoming Spending Review to a major multi-year capital investment programme to modernise the NHS mental health estate." (Department of Health and Social Care, 2018)

Alongside capital investment and greater collaboration and co-operation with the independent sector, participants also identified the need for changes in the culture of practice within inpatient units to manage reduced lengths of stay.

The Culture of Risk Management and Aversion

Participants cited an example from one area that has managed to achieve a significant reduction in the average length of stay to approximately 8-10 days. This required an enhanced level of community and crisis support, but this was not viewed as the only factor. Of more importance was a change in the culture of practice to one that is less risk averse.

Practising this culture change requires constant attention and strong clinical leadership to ensure that the new practices are embedded. One participant cited an example of how a local hospital unit was 'infected by this kind of cultural change' by asking each day, for each patient if they needed to be in hospital. The results were described as a 50% reduction in the average length of stay of 30-70 days and no out of areas placements over a period of six years. However, the practice of culture change needs to be constant and is vulnerable to a change in clinical leadership:

"Within a week of the clinical leadership changing, they were back to the start and the lengths of stay increased again."

Providing consistency in clinical leadership to manage culture and practice change is one of the main challenges. For system leaders it is about creating a climate in which clinicians and practitioners feel confident and supported to take and manage risks:

"It is fundamentally about the culture of risk and fear of consequences."

Providing continuity of senior and clinical leadership to support this kind of culture change is challenging. The Kings Fund report that the median tenure for substantive chief executives was three years and more than half (54 per cent) of substantive executive directors were appointed in the past three years (2015 to 2017), with 18 per cent appointed last year. The churn in senior and clinical leadership is also linked to quality of service provision, but the NHS is characterised by an 'enforced stasis' of interim and short term appointments that is affecting decision-making:

"The NHS is in the middle of a 'strategic ferment' to develop new models of health and care that better meet the needs of local populations. But our interviewees painted a picture of organisations that were placed in 'enforced stasis' by interim appointments, short tenures and short-term decision-making" (Kings Fund, 2018)

The independent review of the Mental Health Act also identified risk aversion as one of the factors that has been leading to greater use of the Mental Health Act:

"But there is another issue, difficult to pin down in statistics, but which has played a substantial role in this rise, and contributes to some of problems that we report in creating and sustaining a genuinely therapeutic atmosphere for those detained. It is the issue of risk and risk aversion." (Department of Health and Social Care, 2018)

Participants agreed with the view reported in the independent review that changing the culture of risk aversion required concerted effort on the part of a range of state actors, in particular regulators such as the CQC:

"The CQC are taking a much stronger approach to risk management and are more likely to impose fines on providers, which is resulting in more risk aversion."

Vulnerable Groups and Place-Based Systems of Support and Care

Arguably, anyone with a mental health problem is vulnerable, but there is increasing recognition that mental health services need to take greater account of those individuals and groups that have greater vulnerabilities.

Participants thought that services and practitioners were good at recognising vulnerability in individual, diagnostic terms, but were less good at understanding vulnerability in populations and groups on the basis of needs:

"We have come a long way in recognising the vulnerability of individuals, but some groups are still under served."

There needs to be an appropriate balance between person centred care that is focused on the individual and service planning and commissioning that takes fuller account of the needs of vulnerable groups.

Veterans and Groups Exposed to Trauma

Veterans with mental health problems are known to experience problems in accessing appropriate mental health services that are sensitive to their particular culture and needs:

"Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care." (Mental Health Task Force, 2016)

NHS England has provided strong leadership in developing specialist provision for veterans with mental problems, including the Transition, Intervention and Liaison (TIL) services and Complex Treatment (CT) services. The provision of care co-ordinators who can support people to manage transition from military life alongside improved access to complex treatment pathways are key to the success of these new programmes. But there is still some way to go in ensuring that the needs of veterans with mental health problems can be met within mainstream mental health services:

"We need to develop specific pathways for veterans into mainstream mental health services, in a way that veterans would recognise as being specific to their needs."

In particular, participants identified the need for trauma-informed services and therapeutic interventions that could address the specific vulnerabilities of the veteran population:

"Trauma is a driver of behaviour that leaves certain groups, such as veterans, vulnerable."

Participants thought that there were groups other than veterans who were vulnerable as a result of trauma, such as victims of sexual abuse and assault, those suffering domestic violence and victims of serious incidents, including terrorist attacks.

One of the difficulties in providing an appropriate service for trauma is that victims may not exhibit symptoms until some time after the event. For example, learning from the Kerslake Report into the aftermath of the Manchester Arena bombing has shown the need for those responding to trauma to follow the NICE guidelines on watchful waiting:

"...a range of 'advisors' being utilised by those affected by the attack who were not following the National Institute for Health and Clinical Excellence guidance in relation to mental health after trauma about 'watchful waiting'."
(Kerslake, 2017)

Left unchecked, exposure to trauma can result in long-term, chronic mental health problems, including Post Traumatic Stress Disorder (PTSD). But if approached solely from the viewpoint of recognised diagnostic criteria, these problems can be missed and the vulnerable individuals and groups that are affected can remain undetected. This is especially important to consider within place-based systems of support and treatment.

For example, understanding vulnerable groups from the perspective of health inequalities. Veterans and victims of sexual assault are not usually understood in these terms, but a population- and place-based approach to identify the needs of these vulnerable groups could improve the way in which services are designed to meet their needs. Parallels to this can be seen in the approach to Black, Asian and Minority Ethnic individuals and groups in the mental health system.

Black, Asian and Minority Ethnic Groups

The independent review of the Mental Health Act places a strong emphasis on vulnerable groups, in particular BAME individuals:

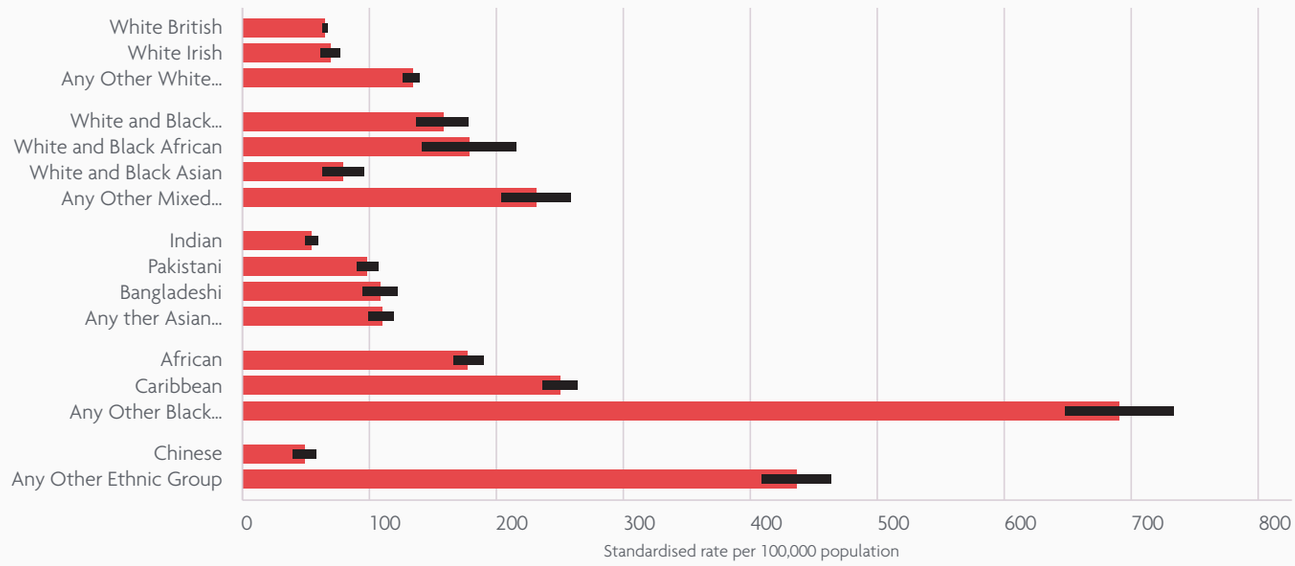
"Profound inequalities exist for people from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes... Adults of Black African and Caribbean heritage are more likely than any other ethnic group to be detained under the Mental Health Act." (Department of Health and Social care, 2018)

Participants spoke about these inequalities, including access to primary and community mental health services:

"We have very high admission rates for young Black men and they do not have good access to psychological therapies in the community."

The evidence on higher rates of detention under the Mental Health Act amongst Black African Caribbean individuals is stark:

Detention rates by ethnicity – 2016/17



Source: NHS Digital

Participants supported the independent review's call for development of organisational competency frameworks to address the inequalities faced by BAME individuals and groups, but this needs to be done as part of a broader system change focusing on place rather than individual organisations:

"We need to think about organisational competency from a systems perspective, it can't be left to single organisations alone."

Participants thought that there needed to be a much stronger focus on addressing the health inequalities of BAME individuals and groups in the mental health system.

In particular, what this would mean from the perspective of place-based service delivery, including consideration of the full range of factors that influence the vulnerability of BAME individuals and groups such as employment, education and social cohesion.

Co-Morbidities and Dual Diagnosis

Participants identified co-morbidities as creating particular vulnerable groups in the mental health system and that this is often missing from national planning frameworks. For example, the NHS LTP talks about the success of Alcohol Care Teams (ACTs) and states that those hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs. LTP goes on to state that this will be supported through funding from the CCGs' health inequalities funding supplement, working in partnership with local authority commissioners of drug and alcohol services.

However, this is not considered as part of the mainstream approach to mental health service provision, despite the fact that participants thought that alcohol and drug use was significant amongst the mental health service user population:

"Alcohol and drug provision needs to be fully joined up with mental health service provision, we will not win health without winning addiction."

Participants also thought that there needed to be greater recognition of the commonalities in behaviours that underline addictions, for example, harmful repetitive behaviours. Dividing commissioning by diagnostic criteria prevented more creative local approaches to developing services that could work more effectively with these vulnerabilities:

"How can we integrate substance use provision? Through networking and supporting across discipline relationships."

At the level of place, this would mean having teams that were not characterised by a particular organisational service model, but could operate across problems with vulnerability as the unifying factor:

"We need focused networks of provision for higher acuity work that is not diagnostic led."

A truly placed-based approach to working with vulnerable groups would involve teams that were unaware of whom they worked for. This is a primary challenge for systems that are currently based on strict organisational and sectoral boundaries, but as one participant put it, *'this is worth it, even if it leads to the dissolution of the Trust.'*

Required Actions to Support Change

Based on the discussions at the Roundtable, this final section of the report seeks to address a number of focused actions that local areas needed to take over the next 12 months to support change. This includes consideration of the steps needed to implement the NHS LTP and what additional support would be required to develop a more integrated, place-based local offer for mental health services.

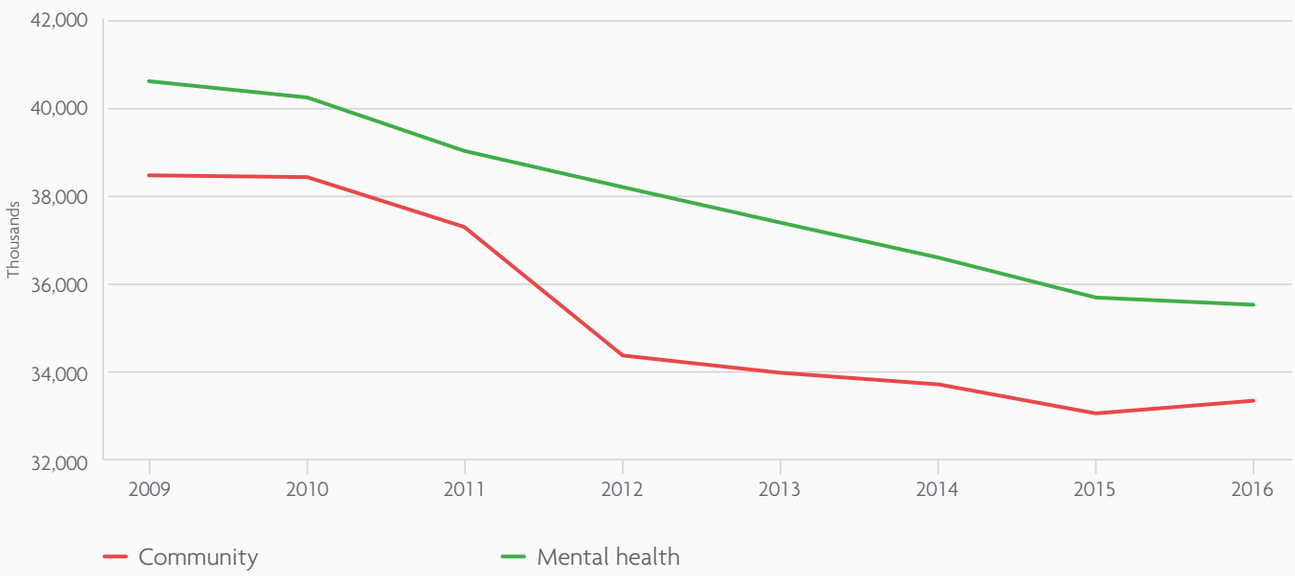
Workforce

Workforce is one of the most critical issues identified by participants that they will face in the next 12 months. The King's Fund estimates that based on current trends the projected gap between staff needed and the number available could reach almost 250,000 by 2030. Mental health and care services are facing unprecedented challenges in recruiting and retaining staff:

"...long-standing objectives to reach parity of esteem between physical and mental health will fail if the NHS cannot overcome the existing deep shortages in mental health staffing." (King's Fund, 2018)

In 2017, the Health Foundation estimated that between 2009 and 2016, the numbers of full-time equivalent mental health nurses and community nurses employed by the NHS both fell by 13%:

Number of full-time equivalent community and mental health nurses in the NHS in England – 2009-16



Source: NHS Digital (2017), NHS workforce statistics.

The fall in numbers of community mental health nurses presents a significant challenge to the plans to move more patient care into the community.

Many of the same issues are affecting the social care workforce, for example, according to the King's Fund, vacancies in adult social care are rising, currently totalling 110,000, with around 1 in 10 social worker and 1 in 11 care worker roles unfilled.

Additional factors identified by participants included Brexit and the departure of EU nationals from the nursing and care workforce and lower numbers of nurses entering university courses:

"Employment levels are falling markedly, so our immediate concern is where the workforce will come from in the short to medium term?"

A survey by the Royal College of Physicians found that 53% of consultants and 68% of trainees said that there were 'frequently' or 'often' gaps in hospital medical cover that raised significant patient safety issues (Royal College of Physicians, 2018).

Participants viewed the lack of specificity on workforce in the NHS LTP as one its major deficiencies, although it does state that a separate workforce plan will be published this year. However, as pointed out by the King's Fund, the risk is that additional funds identified in the Long Term Plan will go unspent if the workforce issues are not addressed:

"...even if commissioners have the resources to commission additional activity, health care providers may not have the staff to deliver it." (King's Fund, 2018)

In the short term a number of actions are required to ensure that planned developments and changes for mental health services can take place and also to ensure that current provision is able to continue to provide and effective care:

- Strengthen resilience factors in the existing workforce – the mental health workforce has traditionally had a high resilience to stress factors and have chosen to work in mental health knowing that it is a stressful environment. However, the factors that supports this resilience such as feeling in control of working patterns, being listened to by managers and peer support need to be strengthened.
- Address discrimination – Black, Asian and Minority Ethnic staff consistently report higher levels of experience of discrimination by managers, staff and patients. NHS Trusts need to have robust action plans to address this and ensure that BAME staff members feel supported.
- Increase access to pastoral support and counselling – when the workforce is expressing higher levels of distress and stress employers need to match this with increased access to pastoral support and counselling. Middle managers, in particular, need to be trained in how to identify and respond to stress within teams.
- Provide more flexible working patterns and roles, for example, older staff members often prefer part-time work and younger staff are known to prefer shorter shifts.

- Education providers need to develop more flexible training programmes that use competency-based learning and skills ladders. New learning methods that enable people to build up and transfer competencies on a more flexible basis could be used to support the development of more effective career pathways, especially for the lower qualified care workforce.

Proactive Rather Than Reactive Regulatory Frameworks

The regulatory environment has become increasingly restrictive and burdensome. It is right and proper that learning from incidents of poor care, neglect and lack of appropriate safeguarding should be strongly responded to. But there is an increasing perception amongst providers that the regulatory framework has become overly intrusive and that this is in reaction to serious cases rather than as a proactive process for improving safety and quality.

As NHS England and NHS Improvement move towards greater integration and possibly merger, it is timely to reflect on the way in which regulation operates and the possible unintended consequences of an overly burdensome regime.

Primary Legislation to Strengthen Integration

Much has been done in recent years to further integration between health and social care, but the so called 'triple integration' of primary and specialist care, physical and mental health services, and health with social care requires primary legislation to enable the scale and impact of delivery envisaged in the NHS LTP. Integration between physical and mental health services in particular requires a much stronger focus.

Sustainable Transformation Partnerships, Integrated and Accountable Care Systems and Multi Community Providers have all been able to move agendas forward, while lacking statutory powers and duties. However, the scale of the challenges ahead and the need for stronger local systems that can take the decisions that will be needed requires the full force and support of an appropriate legislative framework. This should include:

- Putting joint decision-making bodies for CCGs, providers and local authorities onto a similar statutory basis as Health and Wellbeing Boards.
- Changing the requirement on procurement rules from the notion of 'any wiling provider' to the 'most appropriate provider', whether that is an NHS Trust, an independent provider or a community and voluntary sector provider.
- Introduction, through primary legislation, of a shared duty on commissioners and local authorities to develop integrated physical and mental health community services provision.
- Devolution of specialist mental health commissioning budgets to local joint decision-making bodies that include the full spectrum of relevant commissioners and providers, working collaboratively.

Trauma-Informed Service Development for Vulnerable Groups

The NHS LTP places particular emphasis on the needs of vulnerable groups, including children and young people, pregnant women, victims of sexual assault, asylum seekers and veterans. It is increasingly recognised that one of the common factors that makes these groups vulnerable is the experience of trauma, whether that is due to exposure to prolonged stress and violence or through lifelong experiences of discrimination and neglect.

There is a great deal that could be learnt from work with veterans in this regard, both in the UK and in other countries. For example, the Patriots Support Programme in the USA. The programme was born out of the recognition that it was not uncommon for active duty service members and veterans to struggle with depression, post-traumatic stress (PTS), addiction or other behavioural health issues. Having operated for several years with very highly regarded outcomes and development of significant expertise in therapeutic trauma-informed services, the Patriots Support Programme now operates across 12 Centres of Excellence and 13 other facilities designated as Support Service Centres.

In the UK, the Defence Select Committee has recently highlighted a number of serious shortfalls in the current level and quality of service provision for armed forces personnel and veterans in the UK. The Committee has called for a world-class centre for the treatment of mental injuries to be developed in the next 12-18 months. However, given the scale of need and recognising that other vulnerable groups would benefit from trauma-informed service provision, there is an urgent need to consider the development of a wider network of centres of excellence for the UK. This should be done on the basis of open referral with rapid access to high quality trauma-informed therapeutic interventions. New centres of excellence, on a hub and spoke model, could combine intensive inpatient care and treatment with a thorough and integrated community and aftercare programme. A network that can encompass every region will not be built up in the short-term, but drawing on the best practices from other countries such as in the USA, could be done rapidly, with a view to this assisting in the scoping of evidence for a new service specification for at least two centres in the next 12 months.

Organisational Competency Framework to Address Racial Disparities in Mental Health Service Provision

The independent review of the Mental Health Act calls for the development of an Organisational Competency Framework (OCF) to tackle racial disparity, which has at its core service user and carer accountability measures, designed to address this.

Racial disparity in mental health care is an issue that has long been recognised but there remain uncertainties about how to address this from an organisational competency perspective. The independent review states that the OCF should focus on several core areas of competence: awareness, staff capability, behavioural change, data and monitoring, and service development. It goes on to state that there should be regulatory oversight to monitor compliance and attainment at a national level, with patient and carer representatives having an active role in the assessment.

While the principal aim of the OCF, as envisaged by the independent review, is to address the inequalities experienced by Black African Caribbean patients, it should not be limited to this and could be easily adapted for other groups as well.

The concept of the OCF is in keeping with the recommendations from the Crisp Commission (Crisp, 2016), which called for a clear and measurable set of Race Equality Standards for acute mental health services.

It is less common these days to hear talk of institutional racism, but it is undoubtedly organisational bias, whether conscious or not, that lies at the heart of the racial disparities in the mental health system. An OCF to address this must focus on a range of factors and not just those that task orientated, but the very culture of the organisation:

"The specific organisational change management processes that are necessary to address institutional racism for professional organisations need to go beyond primary task systems." (Bashford, J 2008a)

The OCF should be based on both individual and organisational competence. Individual competency is skills-based and relates to individual professional practice in working with diverse communities and individuals. Organisational competence, on the other hand, is defined by the level of maturity in the organisation for addressing equality and diversity across the full range of its functions and policies (Bashford, J 2008b).

A good starting point for development of the OCF would be to pilot this and test out the relevant competencies, practices and policy framework and governance structures that should accompany it. This should be done with the full engagement of BME mental health service users and their families.

References

Bashford, J (2008a) *An investigation into the effectiveness of organisational change management processes for implementing race equality post the Race Relations (Amendment) Act 2000.* PhD Thesis. Preston: University of Central Lancashire.

Bashford, J (2008b) *A basic framework for cultural competency In Fountain*, J and Hicks, J (Eds) *Delivering race equality in mental health care: Report on the Findings and Outcomes of the Community Engagement Programme 2005-2008*. London: Mental; health Development Unit

CQC (2015) *Right Here Right Now: People's experience of help, care and support during a mental health crisis.* London: CQC.

CQC (2018) *Mental Health Act. The rise in the use of the MHA to detain people in England.* London: CQC

CQC (2019) *Brief guide on inpatient mental health rehabilitation services: access and discharge.* London: CQC

Crisp, N Lord (2016) *Old problems, new solutions: Improving acute psychiatric care for adults in England.* London: Independent Commission on adult acute mental healthcare.

Department of Health and Social Care (2018) *Modernising the Mental Health Act Increasing choice, reducing compulsion.* Final report of the Independent Review of the Mental Health Act 1983. London: DHSC

Gershlick, b; Roberts, A; Charlesworth, A; Thorlby, R and Jones, H (2017) *Election briefing: A sustainable workforce – the lifeblood of the NHS and social care.* London: The Health Foundation

Kerslake, Lord (2017) *The Kerslake Report: An independent review into the preparedness for, and emergency response to, the Manchester Arena attack on 22nd May 2017.* Online: *https://www.fbu.org.uk/publication/kerslake-report-independent-review-preparedness-and-emergency-response-manchester-arena*

King's Fund (2018) *The health care workforce in England: Make or Break.* London: King's Fund

Mental Health Foundation (2019). *Health Foundation response to the launch of new 10-year plan for the NHS in England.* Online: *https://www.health.org.uk/news-and-comment/news/nhs-long-term-plan-launch*

Mental Health Task Force (2016) *The Five Year Forward for mental Health.* London: NHS England

National Audit Office (2016) *Mental health services: preparations for improving access.* HC 492. London: NAO

NHSE (2019) *The NHS Long Term Plan.* London: NHSE

Royal College of Physicians (2018) *Focus on physicians: 2017-18 census.* Online: *https://www.rcplondon.ac.uk/projects/outputs/focus-physicians-2017-18-census-uk-consultants-and-higher-specialty-trainees*

For further information please visit our website at www.bbi.uk.com or contact:

Matt Finucane
Senior Programme Manager, Breaking Barriers Innovations
matthew.finucane@dgmi.co.uk
+44 (0)20 7603 5086

Lee Hammon
Chief Commercial Officer at Cygnet Health Care
leehammon@cygnethealth.co.uk
+44 (0)207 123 5706

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