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Ideas that change
health care

Transforming mental health

A plan of action for London

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September 2014





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1 Executive summary

There is a growing consensus that mental health is just as important as physical health in ensuring the health and wellbeing of the population. In London, almost £7.5 billion is spent each year addressing mental illness, while the wider health, social and economic impacts of mental illness cost the capital an estimated £26 billion ([Greater London Authority 2014](#)). Tackling the costs of mental illness has been identified as a priority by the recently established London Health Board; however, there has been little consideration of what is required to meet mental health need in the immediate future, and the unique challenges of achieving this in London. This report describes a vision for the future of mental health provision in London generated through a process of engagement with key stakeholders in the capital.

Focusing on public mental health and adult mental health service provision, this process identified a number of priority areas for attention and corresponding principles for delivery which are shared amongst the stakeholder groups. During the process, several examples of good practice were highlighted, which have contributed towards this vision, but with the recognition that there was limited impact more widely across London.

While stakeholders agreed on what the components of future mental health provision in London should be, the engagement process highlighted that there is no collective vision of how to achieve systemic change. A number of barriers to creating a shared plan of action were identified including: different political and historical agendas among key stakeholder groups; unconstructive communication between stakeholders; insufficient attention to collaboration in developing strategies to improve London's mental health; and weaknesses in commissioning.

Previous attempts to create a vision for mental health provision have often underestimated the systemic nature of implementation and paid insufficient attention to the barriers identified here. This has resulted in limited progress. Taking this into consideration, the stakeholder engagement process has enabled us to identify a number of key steps that would serve to support systemic implementation of this vision. They comprise:



- developing a process of collaborative commissioning to facilitate change
- driving change through collective systems leadership
- ensuring that service users and clinicians are at the core of provision
- using contracting systems to support integration
- building a public health approach to mental wellbeing
- developing pan-London solutions to increase impact
- utilising London's academic infrastructure to disseminate best practice
- creating a new narrative for mental health.

The priorities and principles described here provide a basis for what needs to be done, but the key steps are at the core of achieving this vision. They reflect the strengths of individual stakeholder groups but also the importance of working collaboratively and adopting a shared agenda. Commissioners and providers are at the heart of this process, with other organisations facilitating key elements underpinning delivery and providing an infrastructure for transformation. These organisations include Public Health England, NHS England, academic health science networks (AHSNs) and centres (AHSCs), Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) and strategic clinical networks.

The government's mandate for achieving parity of esteem between physical and mental health ([Department of Health 2013](#)) has put the spotlight on mental health provision. Delivering this joint vision for London's mental health requires the diverse stakeholders that contributed to this report to unite in adopting a different approach. This opportunity to bring together the unique resources, capacities and expertise of each stakeholder group in developing collaborative solutions must not be lost. In the face of finite resources, failure to take advantage of this opportunity may further marginalise mental health provision in the capital. But by adopting a clear, shared agenda for improving the mental health outcomes of Londoners, stakeholders could once again put mental health transformation centre stage.



2 Introduction

In 2006, Lord Darzi laid out a strategy to meet the health needs of Londoners over the next 5 to 10 years. His report, *Healthcare for London: a framework for action* (NHS London 2007), provided a blueprint but largely excluded mental health. The prevalence and economic cost of mental illness in London presents a strong argument for similar attention (Greater London Authority 2014), but beyond the work of the London Health Programmes, there has been little consideration of what is required to meet the future mental health needs of London's population.

Mental health services have undergone a dramatic transformation over the past 25 years, with providers in London and elsewhere developing innovative service models based on multidisciplinary team working and community-based care. There is much that the rest of the health and social care system could learn from this transformation (see the recent report by Gilbert *et al* 2014). But while progress has undeniably been made, there is still much more that can be achieved.

This paper draws on the literature to provide an overview of the current knowledge and thinking around providing for the future mental health needs of the capital's population. It considers mental health and mental health service provision in London, and assesses progress to date on delivering improved mental health outcomes. The paper describes a number of priority areas identified by stakeholder groups as well as the main challenges to effective implementation, and identifies key steps to bringing about systemic change. The vision described is of a collaborative, integrated approach towards mental health that is relevant in London and elsewhere.



About this report

This paper is based on a process of stakeholder engagement undertaken by The King's Fund in 2013. The stakeholder groups (each deriving from or with a special interest in London) included: NHS mental health and primary care providers; social care providers; specialist housing providers; local authority and clinical commissioning group (CCG) commissioners; representatives from NHS England, Public Health England and the Metropolitan Police Service; independent and voluntary sector providers and innovators; academics; clinicians; and service users and carers.

During a series of workshops, stakeholders considered what the future of mental health provision in London would look like; they examined innovative models of care, identified priority areas for action, and considered how changes could be implemented to improve mental health outcomes. The discussions focused on public mental health and adult mental health service provision.

The report has also been informed by interviews with key stakeholders, observation of joint stakeholder meetings, and a review of the relevant literature.



3 The impact of mental illness in London

Mental illness is the single largest cause of disability in the United Kingdom, contributing up to 22.8 per cent of the total burden, compared to 15.9 per cent for cancer and 16.2 per cent for cardiovascular disease ([World Health Organization 2008](#)). No other set of conditions matches the combined extent of prevalence, persistence and breadth of impact ([Friedli and Parsonage 2007](#)).

Among people under 65, mental illness accounts for nearly half of all instances of ill health ([Centre for Economic Performance Mental Health Group 2012](#)). Mental illness often begins early in life and affects people over a long period ([Royal College of Psychiatrists 2010a](#)). Depression and anxiety disorders are by far the most common mental illnesses, affecting 15.8 per cent of the adult population in London. The prevalence of other mental illnesses varies, but it is estimated that 7 per cent of London's population have an eating disorder, 1 in 20 adults have a personality disorder, and 1 per cent are registered with their GP as having a psychotic disorder such as schizophrenia, bipolar disorder or other psychoses ([Greater London Authority 2014](#)).

The prevalence of depression and dementia in London is below the national average ([British Medical Association 2008](#)). There is no national comparative data on the prevalence of psychotic disorders; however, with more than two-thirds of London boroughs in 2011 having an estimated incidence of new cases of psychosis far above the national average ([Mental Health Dementia and Neurology Intelligence Network 2014](#)), it is likely that the prevalence of psychotic disorders is higher than the national average in many areas of London.

The incidence of mental illness varies sharply between boroughs, with some mental illnesses twice as common in deprived parts of London compared with in the least deprived ([People's Inquiry into London's NHS 2014](#)).



Impact on health and wellbeing

Mental illness has a huge impact on the health and wellbeing of individuals. People with mental health problems are at higher risk of experiencing significant physical health problems; they are more likely to develop preventable conditions such as diabetes, heart disease, bowel cancer and breast cancer, and do so at a younger age. This contributes to a situation whereby people with serious mental health problems die 20 years younger (on average) than the general population (Newman and Bland 1991; Brown *et al* 2010). Rates of mental illness – particularly depression – are between two and three times more common in those with long-term conditions, including coronary heart disease, cancer, diabetes, osteoporosis, multiple sclerosis, immunological problems and arthritis compared with the general public. Mental health co-morbidities contribute significantly to poor physical health outcomes and higher treatment costs; it is estimated that £1 in every £8 spent on treating a long-term condition is linked to a co-morbid mental illness (Naylor *et al* 2012).

Mental illness further affects the way individuals manage their health and interact with services. People with mental health problems are more likely to misuse substances (Coulthard *et al* 2002), and less likely to be physically active (Osborn *et al* 2007). Furthermore, they are less likely to attend medical appointments (Mitchell and Selmes 2007), and less likely to adhere to treatment (Conley and Kelly 2001) and self-care regimens (Katon 2003; Benton *et al* 2007). Indeed, patients with a range of medical conditions are three times less likely to take medications as recommended if they also have depression (DiMatteo *et al* 2000).

Wider impacts on society

The negative impacts of mental illness do not stop at health systems. Mental illness is associated with increased levels of worklessness, reduced productivity in the workplace, and increased rates of sickness absence (Sainsbury Centre for Mental Health 2007). Seventy per cent of people with psychotic disorders are economically inactive, while self-reported depression is the single most important cause of workplace absenteeism in the United Kingdom (Gray 1999). Losses in work-related output to London business and industry due to mental illness are estimated at £10 billion per year. The resulting losses in taxation associated with worklessness are estimated to be at least £1.98 billion (Greater London Authority 2014).



The social care costs of mental illness are substantial. Taking into consideration the benefits paid to individuals with a medical condition, in 2011/12, an estimated £0.2 billion was spent on Disability Living Allowance for people with a mental health problem living in the capital, with a further £0.76 billion on Incapacity Benefit and Employment and Support Allowance ([Greater London Authority 2014](#)).

Mental illness also affects family members and carers. An estimated 88,000 people in London provide informal care for people with mental health problems ([Greater London Authority 2014](#)). This contributes to substantial savings in social care, but often has negative effects on the health and wellbeing of those providing that care. Furthermore, in the absence of adequate support, parents with mental health problems can have both direct and indirect intergenerational effects.

Overall, the health, economic and social impacts of mental illness result in costs to the capital of an estimated £26 billion each year ([Greater London Authority 2014](#)). Government spending on mental health services represents the largest proportion of spending for a single disease category and accounts for 11 per cent of the NHS secondary health care budget ([Department of Health 2011a](#)). In 2011/12, £1.43 billion of a total budget of £6.63 billion for working-age adult mental health services in England was spent in London, with additional expenditure in primary care of £0.60 billion. It is estimated that almost £7.5 billion is spent each year to address mental illness in the London community ([Greater London Authority 2014](#)). Meeting the mental health needs of London's population is a core component of ensuring the future health and economic sustainability of the capital.



4 Providing for the mental health of London's population

Determinants of mental health needs

The mental health needs of London's population have been examined by a number of organisations (Johnson *et al* 1997; Levenson *et al* 2003; London Health Programmes 2011; Greater London Authority 2014). They have focused on three factors that are important in determining these needs. The first is the high level of deprivation in London. More than half of London's boroughs are within the top 30 per cent of the most deprived areas of England, and 10 boroughs are among the top 10 per cent (Department for Communities and Local Government 2011). Prevalence of mental illness is greatest in the most deprived parts of London (London Health Programmes 2011).

The second factor is the ethnic diversity of London's population. London has more than 40 per cent of the UK's black, Asian and minority ethnic population (Greater London Authority 2008). It is also the focal point for many people who arrive in the country, including refugees and those seeking asylum. Of the 50 local authority areas in the United Kingdom identified as 'most diverse', 30 are in London (Office for National Statistics 2012). Many black and minority ethnic (BME) communities face greater social adversity and exposure to risk factors such as poverty and discrimination, which have an adverse effect on mental health (Department of Health 2009); at the same time, delivering services to meet the needs of ethnic groups can present a number of challenges. Black and Asian ethnic groups are more likely to have lower mental health wellbeing than the London average.

The third factor is the transience of London's population. As a capital city, it has significant turnover of people each year, along with movement between boroughs (particularly in inner London). This also affects the extent to which providers



can deliver seamless services and support (Care Services Improvement Partnership *et al* 2005).

Overview of mental health provision

Following the reforms introduced by the Health and Social Care Act 2012, responsibility for the mental health and wellbeing of London's population (as with other parts of the country) lies in the hands of organisations with varying geographical and population-specific remits. In London, this involves 32 clinical commissioning groups (CCGs), 33 local authorities, 3 local education and training boards, the London offices of NHS England and Public Health England, 10 mental health trusts, and other non-NHS providers. The London Health Board provides leadership on pan-London health issues and is currently developing its mental health priorities, while a number of pan-London mental health programmes previously led by NHS London continue within individual organisations, including UCL Partners, the Anna Freud Centre, and NHS England.

The structure of mental health service provision in London is not dissimilar to other areas of the country. The vast majority (86.1 per cent) of adult and older people's mental health services in London are delivered by statutory providers ([Mental Health Strategies 2012](#)), with the largest proportion delivered by 10 mental health trusts, seven of which have achieved foundation trust status. These trusts are relatively stable, with strong leadership and established relationships with different boroughs.

In addition to providing for the local population, a number of trusts deliver specialist services such as the National Deaf Services and Broadmoor Hospital, as well as mental health input into acute care and primary care in the form of liaison psychiatry and professional support. More recently, several of these trusts have extended their traditional boundaries, delivering individual mental health services such as for the Improving Access to Psychological Therapies (IAPT) programme across London and beyond, and entering the realm of community health service provision.

NHS mental health service provision is supported by independent and voluntary sector organisations that deliver a range of generic support and specialist provision. Some of this is mental health-specific, but elsewhere mental health is a component of care within a service designed to target particular population groups. There are an extensive and diverse range of organisations involved in providing this support in London.



The number of people using adult and elderly NHS secondary mental health services per 1,000 population in 2010/11 was significantly higher than the national average in more than three-quarters of London's boroughs ([Health and Social Care Information Centre 2011](#)). Furthermore, hospital admission rates from 2009/10 to 2011/12 were significantly higher than the national average in half of London's boroughs, particularly inner city boroughs. However, there is considerable variation between boroughs and by disorder. The data show that London has higher than the national average:

- rates of admission in more than half of boroughs for depression and more than three-quarters of boroughs for psychotic disorders in 2009/10 to 2011/12 ([NHS Choices 2012](#))
- number of days spent in hospital per 100,000 population in more than half of boroughs in 2013/14
- numbers of people on the Care Programme Approach per 100,000 population in more than half of boroughs in 2013/14 ([Health and Social Care Information Centre 2011](#))
- number of contacts with a community psychiatric nurse per 1,000 population in 2010/11 ([Health and Social Care Information Centre 2011](#))
- total contacts with mental health services per 1,000 population in 2010/11 ([Health and Social Care Information Centre 2011](#)).

In many areas of London, the use of mental health services also appears to be higher than the national average. Although in some areas this may reflect greater prevalence and demand, elsewhere the pattern of usage suggests that other factors are likely to play a more important role. These may include differences in severity of illness, service configuration and local practice.

One of London's unique strengths is that it has become a focus of academic research into mental health, with some of the leading institutions in the world situated in the capital. These organisations focus on developing new insights into mental illness, new models of service delivery, and evaluating the effectiveness of interventions. London has also been awarded a number of grants to develop an infrastructure that



supports the translation of this expertise into practice through the partnership of academic institutions with local NHS trusts and the communities in which they operate.

Three designated academic health science centres (AHSCs) in London bring together academic institutions with NHS providers to facilitate improvements in patient care and health care delivery. They are supported by three academic health science networks (AHSNs), which facilitate partnerships across academic institutions, all parts of the NHS and other health care providers to accelerate the adoption and spread of innovation, including clinical research, informatics, education and health care delivery. Finally, London's three Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) bring academic partners and NHS organisations in each locality together to embed applied health research methods within health care organisations across a wide geographical area to improve patient outcomes.

This wealth of expertise, in addition to local innovation, has led to a number of exemplary services and models of care delivery spread across London's boroughs. This includes one of the most notable early intervention services in England, recovery colleges in the North and South West of London, and crisis houses providing alternatives to hospital admission in no fewer than six London boroughs. Responding to the diversity of London's population, services have developed additional expertise in working with people from BME communities and those experiencing homelessness. Many boroughs and providers are also involved in local and national pilots such as the NHS England Liaison and Diversion trial. The boxes below give examples of some of the most innovative approaches, but there are many others.

London has not been immune to wider criticisms of mental health support over the past decade. Indeed, recently, the London Health Programmes conducted a series of workshops to explore some of the issues affecting mental health service provision in the capital ([London Health Programmes 2011](#)). They found that:

- community mental health workers often had high caseloads that resulted in lower access to evidence-based interventions
- poorer-quality interventions were being provided, which were less likely to be evidence-based



- mental health trusts had high numbers of stable patients with long-term conditions in secondary care despite the availability of local enhanced services
- there was high accident and emergency (A&E) usage as a means of accessing mental health care, leading to revolving door and high cost
- there was low access to services for carers in their own right
- there was poor translation of research into service improvement.

Examples of innovative mental health practice in London

South West London Recovery College
 The Recovery College is the UK's first mental health recovery study and training facility. Taking an educational approach to supporting recovery from mental illness, it provides a range of courses and resources for families, friends, carers and staff. The college aims to support people to become experts in their own self-care and for others to better understand mental health conditions. The college is now a national demonstration site for the Implementing Recovery through Organisational Change programme.

Drayton Park Crisis House
 Drayton Park was the first women-only residential mental health crisis facility in the UK. The project offers residential and non-residential support within a domestic setting, providing an alternative to hospital admission. Uniquely, it can take mothers with their children when necessary. The subject of several research studies, it has provided a basis for the further development of crisis house models.

The Collaborative - Living Well in Lambeth
 The Collaborative is a platform bringing together service users, carers, GPs, public services, commissioners and providers from different sectors. Built on a Total Place approach, their aims include improving access, providing better support in the community, increasing the capacity of primary care, and increasing choice. Through a process of co-production, stakeholders are rethinking how mental health services are provided to co-design a roadmap to deliver change at scale.

3 Dimensions of care For Diabetes (3DFD) team at King's College Hospital
 The 3DFD team is a model of care for people with diabetes that pays particular attention to mental and social wellbeing. Delivered in partnership with Thames Reach, it focuses on patients struggling with diabetes and social problems such as homelessness, unemployment, domestic violence, illiteracy and debt. With three prestigious awards under their belt, the team were most recently named BMJ Diabetes Team of the Year 2014 for their work in improving patient outcomes by integrating medical, psychological and social care.

NHS England's Primary Care Mental Health Leadership Development programme
 Developed in collaboration with UCL Partners, the leadership programme brought together national experts, including patients and families, to deliver a series of workshops over 10 days to support primary care mental health leadership. The programme aims to support leaders to drive improvements in mental health across London in commissioning and service provision. Its success has led to a roll-out of the programme nationally.



Overall, there was a lack of convergence between service users, carers, providers and commissioners when it came to satisfaction. Service user satisfaction was particularly low, with many needs not being met; as a region, London was identified as performing poorly in terms of patient satisfaction. Some of the persistent challenges facing London's mental health service provision that were highlighted are outlined in the box overleaf.

There is no doubt that the high prevalence of mental illness in London (particularly in deprived areas), the higher-than-average number of people with complex needs, and a diverse and transient population present challenges for service provision. Limited access to physical resources such as appropriate housing confounds this situation ([National Mental Health Development Unit 2010](#)). Furthermore, disproportionate cuts in the funding allocated to London's local authorities limits expenditure on core aspects of social care provision while reducing the capacity to invest in interventions to support positive mental health and the prevention of mental illness ([London Councils 2014](#)).

However, there are also wide variations in the availability, quality and effectiveness of specialist services ([London Health Programmes 2011](#)). The findings of the London Health Programmes report suggest that the focus on mental health services, limited mental health expertise at other points of access and poor integration all serve to fragment care pathways, resulting in poor patient experience, particularly in times of crisis. The complexity and co-ordination of London's NHS structures and systems for commissioning and delivering services presents an underlying challenge in ensuring the coherent development of the city's mental health services ([Levenson et al 2003](#); [Ham et al 2013](#)).



Persistent challenges for mental health service provision in London

Identified by the London Health programmes

- **Current systems overlap, with a lack of coherent pathways**
The degree of specialism in mental health has impacted on communication between services, leading to duplication of assessment and people falling through the net.
- **Variability of primary and secondary care and their interface**
The quality of assessment in primary care is variable; few GPs have an interest in mental health, and their knowledge of secondary care services, support for carers and access to psychological therapies is variable.
- **Lack of integration between physical and mental health care**
There is a lack of co-ordination between physical and mental health services and a failure to proactively engage with people's mental health conditions outside of mental health services.
- **Lack of consistent and accessible data on activity and outcomes**
Outcome measures are not deployed or reported consistently.
- **People do not know how to get help in a crisis**
The quality of crisis plans is variable and care plans do not always cover crisis planning. Different service configurations mean that other health care professionals, police, and ambulance staff find it difficult to identify the most appropriate service.
- **Delays in getting access to the right care**
There is a lack of mental health expertise within A&E departments or GP surgeries. The police and ambulance staff take people with mental health conditions to hospital when they do not need medical intervention. People often have multiple assessments by different professionals and are advised to go to a different service.
- **Some groups are more likely to reach crisis point before accessing services**
African-Caribbean people are more likely to have mental health problems but less likely to access services. Homeless people are likely to present late with serious mental health problems and may use A&E due to poor access to primary care. Refugees and asylum-seekers are more likely to experience mental health problems but find it difficult to access help because of uncertainties about eligibility.
- **Recovery is about more than mental health services**
No single person or service can address the wide range of factors that affect and are affected by long-term mental health conditions.



5 Understanding the limitations of current mental health provision

Given the attention that London's mental health system has received from policy-makers, a key element of developing a shared vision is identifying some of the underlying issues. Two principles underpin the delivery of effective mental health provision. The first is that access is sufficient and appropriate so that everyone who needs help can get it. The second is that treatment is both timely and effective in order to minimise the negative impact of illness. This section discusses these twin challenges, along with the limited attention given to the prevention of mental illness.

Issues around access to care have been raised in a number of previous reports. Areas of particular concern include:

- access to psychological therapies
- access to health care for people with co-morbid physical and mental health problems
- access to services by people from particular groups (such as homeless people or young people)
- access to wider support with employment and housing
- access to appropriate care at the point of crisis.

One of the most notable examples is access to psychological therapies, since the Improving Access to Psychological Therapies (IAPT) programme with initial ring-fenced funding was specifically set up to facilitate access on a national scale. The programme aims to support the implementation of psychological interventions



that have been demonstrated to be cost-effective for the treatment of depression and anxiety (National Institute for Health and Clinical Excellence 2004a, 2004b), which are by far the most prevalent mental health conditions. The relative low cost of psychological therapies in relation to their effectiveness in improving outcomes means they are a viable option for provision at scale; the increased expenditure required to ensure access is far outweighed by the resulting savings on NHS physical care alone (Centre for Economic Performance Mental Health Group 2012).

Despite this, however, access remains problematic. A study of IAPT services in London identified that long waiting times to access services was a problem that could result in significant distress (Hamilton *et al* 2011), a situation that is mirrored nationally (Mind 2013). Analysis undertaken by the London School of Economics (Centre for Economic Performance Mental Health Group 2012) suggests that the scale of implementation has been insufficient in relation to demand and, in some cases, provision has been cut.

Overall, it is estimated that only a quarter of people with depression or anxiety are receiving treatment, compared with the vast majority of those with physical conditions such as diabetes and hypertension (Centre for Economic Performance Mental Health Group 2012). Furthermore, many people have to request psychological therapies rather than being offered them, and after being assessed, as many as 10 per cent are not offered any treatment (Mind 2013). The Mind survey also identified limited access to choice of therapy and poor rates of access for particular at-risk groups such as people from black and minority ethnic (BME) communities, older people and children.

At the opposite end of the care pathway is provision for those who are acutely unwell and in crisis – usually the most vulnerable people who are at risk of the worst outcomes. Crisis care was identified as a key area for improvement in London (London Health Programmes 2011) and continues to receive particular attention (Lintern 2013). An independent inquiry by Mind (2011) found that nationally, access to mental health crisis care services varied widely, with some areas lacking community-based options and insufficient 24-hour provision, leading to people in need of urgent care being sent many miles from their family and community.

In London, a Freedom of Information request by the *Health Service Journal* (Lintern 2013) highlighted that many mental health trusts were, on occasion, operating with



no beds available. In one, this resulted in the inappropriate use of seclusion rooms as bedrooms (Care Quality Commission 2014), while the Medical Director of the South London and Maudsley NHS Foundation Trust reported that they frequently sent people across the country due to a lack of inpatient capacity – a situation he described as ‘inefficient and unsafe’ (Buchanan 2013). However, a retrospective utilisation review conducted by doctors in the same trust found that over a 32-month period, approximately 30 per cent of patients admitted onto an inpatient ward could have been cared for in a community setting (Stanton 2012). This indicates that the problem is not simply a matter of the number of beds, but also relates to the failure of community teams to help reduce avoidable admissions. The authors concluded that input from the crisis resolution home treatment (CRHT) team was crucial to ensuring appropriate admission, alongside the provision of viable alternatives to hospital.

Effective CRHT teams have proved successful in reducing length of stay (McCrone *et al* 2009) and improving quality of care (Kingdon 2011), often reducing the costs of inpatient care. The ability to deliver these outcomes is dependent on effective implementation of the approach and the systemic management of crisis care pathways as a whole. Despite this, a report by the Audit Commission (2010) found that there was wide variation in admission rates even after adjusting for the needs of different populations, in addition to variation between lengths of stays and spending on crisis CRHT teams. The Audit Commission questioned whether all CRHT teams were operating at their full potential. Given that rapid access to assessment and provision of a full ‘gatekeeping’ service are important factors in reducing admissions, the limited provision of full 24/7 access and the variable involvement of teams in gatekeeping inpatient beds may have been contributing factors (Audit Commission 2010; Lloyd-Evans and Johnson 2014). Service users have also reported that CRHT services are not always readily available as intended (Onyett *et al* 2008; Mind 2011).

The reconfiguration of CRHT services undertaken by the North East London NHS Foundation Trust highlighted during our stakeholder engagement sessions supports the conclusion that strengthening these services can help to support people in the community and reduce hospital admissions. With increased oversight of care, 24-hour provision and a gatekeeping role, the new service reports significant reductions in bed utilisation and out-of-area placements.



These examples are not unique, and reports on mental health care provision have highlighted a number of other areas of concern in relation to the delivery of treatment. They include:

- quality of inpatient care
- use of secure care
- provision for people from African and African-Caribbean backgrounds
- support for carers
- treatment of people with mental health problems in the criminal justice system
- choice over aspects of treatment, including setting, type of treatment, and practitioner.

Many of these issues appear to be endemic within the mental health system and are not isolated to an individual provider or geographic region, resulting in a system described by the Chair of the Schizophrenia Commission as one in which ‘people were being badly let down... in every area of their lives’ ([The Schizophrenia Commission 2012](#)). The fact that there are good examples of mental health service provision suggests that improvements can be made, but there are barriers to achieving this consistently across London.

It should be noted that much of the focus on mental health provision to date has been on improving the outcomes of those with existing mental health problems. As we look towards meeting the future mental health needs of London’s population, a number of challenges arise, including persistently high levels of psychiatric morbidity, increasing levels of co-morbidity, and an ageing population with significant health and social care needs. This calls for a new focus on reducing demand through promoting positive mental health and preventing mental illness.

While the two are related, good mental health has benefits beyond those of preventing illness, including improved educational attainment, better physical health, increased social participation, healthier lifestyle choices such as giving up smoking, increased resilience to adversity (Campion *et al* 2012), and crime



reduction (Friedli and Parsonage 2009). This extends the remit for intervention beyond the traditional boundaries of health to local authorities and public health bodies with a requirement to support positive mental health, mental health awareness and resilience at a community and population level. As with other areas of the country, London is in the early stages of developing public mental health approaches, and it is encouraging that these have been identified as a priority by the London Health Board.



6 A shared vision for the mental health and wellbeing of London

In an effort to prioritise improvement and develop a system that is capable of addressing existing issues as well as accommodating future need, organisations have, over the years, created a consecutive number of ‘visions’ for mental health provision, including the national mental health strategy, *No health without mental health* (Department of Health 2011b). The most recent report to examine the future of mental health services, *Starting today*, presents a national vision for improvement within a 20- to 30-year period and is probably the most systemic and ambitious consideration of provision for mental health and wellbeing to date (Mental Health Foundation 2013). The report identifies a number of priority areas that provide an underlying framework for the delivery of interventions (*see* box opposite).

In focusing on the components required for delivering mental health services, the vision has relevance for a broad range of organisations. However, as a national overview, it does not attempt to account for local needs and variation. Given the focus of clinical commissioning groups (CCGs) and local authorities on commissioning to meet the needs of local populations, there is a need to consider how these priorities are reflected in London and whether variations or additional considerations are required to account for the unique nature of London.

The King’s Fund stakeholder engagement process

The aim of our stakeholder engagement process was to bring together the diverse set of agencies with a role in improving London’s mental health, along with service users and carers, to develop a shared vision for the future. In deciding the priority areas for action, stakeholders were asked to consider: what works and what does not work; what the needs of different groups are; the unique issues facing London, and how each of these could be met. The group was asked to focus on two key areas:



Priority areas in the *Starting today* vision of mental health services

1. Personalisation
2. Self-management
3. Mental health in primary care
4. Crisis care and community support
5. Collaborative working and integrated care
6. Early life
7. Later life
8. Workforce
9. Information sharing
10. New technology
11. Public mental health
12. Stigma

supporting the mental health and wellbeing of the wider public, and the provision of acute care for those with mental health problems. A synthesis of the event identified seven priority areas. These are presented below, supported by illustrative quotes from service users and carers.

Public mental health

- *A focus on children and young people*
To maximise impact, public health interventions should focus strongly on the early years, children and adolescents. Public health programmes should seek to build resilience and social skills, while at-risk groups such as looked-after children should be targeted to prevent the development of mental illness.
- *Inclusion of people with mental health problems in prevention activities*
Many existing public health programmes fail to consider the needs of those with mental health problems. Public health prevention programmes should



seek to include people with mental health problems and provide appropriate support to maximise benefit.

- *Building a healthy and supportive community*
The communities that we live in support our wellbeing and mental health. Part of creating a healthy and supportive community is developing mental health awareness and literacy among staff involved in public health provision and the wider community, as well as tackling stigma against mental illness. A second element is providing support for the broader determinants of mental health, including housing and employment.

Acute mental health care

- *Improving accessibility and availability of support*
Locating mental health services in community settings such as libraries and GP practices, and enabling health and social care staff working in the wider community to support people with mental health problems, will improve accessibility and availability.
- *Crisis care*
The core role of mental health services was often seen as managing people, and when people felt they were deteriorating or really needed help, some mental health services were seen as inflexible and unresponsive. The primary function of mental health services should be to prevent periods of illness; but when a person is in crisis, they need easy access to services that are responsive and provide appropriate help.
- *Patients taking a greater role*
There is widespread support for greater service user involvement and leadership. This includes individuals taking a greater role in managing their health and care, organisations employing people with mental health problems in a peer worker capacity, and working in partnership with commissioners to design and develop services. The appropriate opportunities need to be backed up with a focus on empowering patients and giving them access to the support, tools and knowledge needed to participate. At the same time, staff involved in providing services need to support, trust and respect service users to take on a greater role.



I want support to find my own way through. Taking responsibility for your own health can be difficult at times but it's imperative for recovery.

- *Improving interfaces of care*
The different models of care, tiers of provision and provider organisations have resulted in a system that is not understood, either by those within it or those outside of it. Attention needs to be paid to developing care pathways where the purpose of each element is transparent and the transitions along the pathway are managed to reduce duplication and ensure continuity.

Principles underpinning delivery of mental health

The stakeholder engagement workshops also identified the following principles that should underpin delivery:

- *Collaboration/integration*
There was a general consensus that more integration would be beneficial. This could involve sharing protocols between agencies, developing collaborations for mutual benefit, and use of models such as co-production. Other possibilities include embedding mental health within non-mental health services and using intermediaries to facilitate access to services to meet the needs of an individual. There may be benefits of greater collaboration across CCG boundaries and pan-London approaches that address population mobility and facilitate continuity and access.

You know, people that have never done this kind of thing before, you know, confidentially participating in a group with very senior people was fantastic to see.

- *Equality*
This includes equity with physical health services in terms of resource allocation and outcomes, as well as equity of access and availability of services. It also covers equity of power between service users, providers and other organisations.

There should be more collaboration between people who have mental health problems and the professionals who treat them. Both sets of people would be on an equal footing and have each other's opinions taken with equal importance.



- *Involvement and engagement*
These should be central to all aspects of mental health service design, delivery and evaluation.
- *Patient-centred*
Providing services is not enough; they need to reflect the needs and values of those using them, improve the patient experience, and enable staff to provide high-quality care.

I appreciate when staff, sometimes quite literally, go out of their way to listen and sometimes to be less formal – eg, taking time to read my poems. This extra generosity really touched me deeply and proved to be one of the most influential factors in my recovery.
- *Embedded within the community*
People do not live their lives in health services. Mental health services should be embedded within the community, taking into account the holistic needs of individuals and the interaction between health and other areas of people's lives. This means creating communities that are accepting and supportive of people with mental health problems, supporting people to play an active role in the community, and drawing on community resources to achieve this.

Individualised approaches that meet the individual's set of circumstances best and open the right doors are important... and finds a way to play a useful role in society as we would wish for ourselves.
- *Holistic*
Most mental health service provision focuses on when people are ill. Greater attention should be paid to developing a more holistic view of mental health that considers what is necessary to support people to maintain their health and wellbeing, and to ensure quality of life not just when people are ill but also when they are well.
- *Preventive*
The primary role of commissioning for mental health should be to prevent illness and promote positive mental health, both for those who have existing mental health problems and the wider public.



- *Recovery-oriented care*
All mental health provision should be recovery focused. The recovery model stresses the importance of empowering people to take an active role in determining their needs and goals and supporting them to achieve this – not just focusing on treating or managing their illness.

I want encouragement and support from services to continue with my goals, going to university or getting into work.

It is important to note that the priority areas and principles identified by our stakeholder groups are not new or unique to London. As such, the basis for what Londoners want in terms of the underlying principles of good-quality support for mental health and wellbeing are similar to those elsewhere in the country – although they may need to be implemented in different ways.

It is also important to note that with the exception of crisis care, the priorities identified all represent improvements at a systemic level, including but not limited to mental health services. While the *Starting today* report represents a vision of the future in 20 to 30 years' time, the fact that its recommendations overlap with the principles identified by our stakeholder engagement process covering the next five years suggests that far from a fix-it solution to the problems highlighted in London, stakeholders are seeking system-wide change that lays new foundations for the provision of services to support mental health and wellbeing.



7 Understanding mental health transformation

The most fundamental challenges to improving mental health in London appear to be systemic ones, not limited to any single agency or organisation. This can be illustrated by examining the case of physical health care for people with mental health problems (*see box below*).

Physical health care for people with mental health problems

In 2012, the Schizophrenia Commission described the poor physical health of individuals with schizophrenia as constituting 'neglect' ([The Schizophrenia Commission 2012](#)). The links between poor physical health, mental health and mortality have long been established (Newman and Bland 1991). This issue was highlighted as a systemic problem in the UK in the early 2000s and continued to feature in reports throughout the decade, reinforcing the link between poor physical health, medication and lifestyle and the need to improve monitoring of individuals at risk ([Seymour 2003](#); [Rethink Mental Illness 2005](#); [Mental Health Foundation 2007](#); [Royal College of Psychiatrists 2009a](#)).

The first guidelines from the then National Institute for Clinical Excellence (NICE) on the treatment of schizophrenia highlighted similar concerns and recommended that routine physical health checks should form a core component of care (NICE 2002). This was subsequently reinforced by guidance for commissioners ([Department of Health 2006](#)). Most recently, the physical health of people with mental health problems has formed a core component of the Mandate from the Secretary of State to the NHS Commissioning Board to achieve measurable improvements in outcomes ([Department of Health 2013](#)). The repeated re-emergence of this topic suggests that despite a wealth of evidence and policy support, adequate progress has not been made.

Why is this? One of the main challenges has been an inability to address key contributing factors. Take, for example, weight gain associated with unhealthy lifestyles and the iatrogenic effects of psychotropic medications - one of the most established contributing factors and an area where there are clear policy recommendations. Yet in some areas, fewer than 70 per cent of those at risk are having their weight monitored ([Rethink Mental](#)



Illness 2013), and fewer than 30 per cent of people with schizophrenia have a basic annual physical health check (Royal College of Psychiatrists 2012). Across the London boroughs, patients with schizophrenia are significantly less likely to receive basic physical health checks such as monitoring of body mass index (BMI) and blood pressure than patients outside of London (Quality Intelligence East 2013).

Another factor thought to account for a large proportion of mortality among people with mental health problems is smoking. Smoking is around twice as common among people with mental health problems, who account for a third of all cigarettes smoked in England (Royal College of Physicians and Royal College of Psychiatrists 2013). Smoking cessation interventions that are effective in the general population are also likely to be effective in people with mental health problems, who are just as likely to want to quit as those in the general population. Furthermore, smoking cessation does not exacerbate symptoms of mental illness and actually improves symptoms in the longer term.

However, in contrast to the marked decline in smoking prevalence in the general population from 45 per cent in 1974 to 20 per cent in 2010 (Jarvis 2003), there has been little if any change in smoking prevalence among those with mental health problems over the past 20 years. Smoking remains a widely accepted component of the culture of many mental health settings, with a patient's smoking status often not recorded, and only a minority of people receiving appropriate help. Finally, access to community-based cessation services may prove problematic for some people with mental health problems; for those that do get help, rigid performance targets can limit the investment of services in supporting people with mental health problems who may take longer to quit (Rethink Mental Illness 2013).

The failure to address premature mortality lies with multiple stakeholders. Clinical practice often fails to address risk factors, either with patients or more systemically within care planning. A lack of clarity and communication between mental health and primary care providers around responsibilities for the physical health care of those receiving mental health services leads to monitoring being done by neither (Rethink Mental Illness 2013). High rates of smoking among people with mental health problems have generally been accepted, and provider policies on smoke-free environments have received insufficient monitoring and support (Royal College of Physicians and Royal College of Psychiatrists 2013). Furthermore, despite the clear lack of parity in outcomes, commissioners from both health and local authorities have failed to commission appropriate services to address these health inequalities or hold providers sufficiently to account for physical health outcomes. Finally, in repeatedly restating the case for improvement without identifying the means to achieve it, policy analysts and policy-makers may themselves have been complicit.



The limited progress in tackling the physical health of people with mental health problems is not unique and an examination of reports by the Royal College of Psychiatrists highlights a number of other areas of practice in which issues related to poor treatment and health outcomes remain unaddressed (Royal College of Psychiatrists 2009b, 2010b). With the wealth of evidence and recommendations, it is clear that traditional methods of addressing mental health outcomes in terms of ‘what’ should be done by ‘whom’ have had limited impact at scale, and that a more systemic approach is required that considers ‘how’ the roles and responsibilities of different stakeholders can be brought together to promote synergistic approaches to delivering change.

Identifying barriers to systemic change in mental health

There is a broad consensus that a number of barriers stand in the way of implementing systemic change in mental health. The most commonly noted barrier is funding, which forms a core element of the debate on achieving parity of outcomes with physical health services. Mental health has garnered the reputation of being the ‘Cinderella service’ underpinned by a perception that it has not received a fair share of investment. This perception is not unfounded – at a national level, between 1990 and 1995, the proportion of spending on mental health services fell, even though resources for hospital and community health services were rising in real terms (Rankin 2004). While this was followed by a number of years in which the budget for mental health services grew in proportion to hospital and community services, this may now have ended. In 2011/12 and 2012/13, real-terms growth in mental health spending lagged behind acute hospital spending (Lafond *et al* 2014), and the experience of the recent differential tariff deflator suggests that this trend may continue. While it is difficult to make like-for-like comparisons of the demand pressures facing the two sectors, a declining share of funding going into mental health is difficult to square with parity of esteem with other areas of health care.

Although the total amount of funding is influential, it is how that funding is allocated that is key to implementing change. Nationally the allocation of ring-fenced funds alongside clear targets has been important in supporting implementation in mental health, including specific service improvements and transformation initiatives (Gilbert *et al* 2014). However, on the ground, decisions around allocation are often influenced by a range of other factors. Competing local priorities or financial constraints, alongside the effective management and



organisation of finances by commissioners, have limited implementation of some recommendations (Audit Commission 2005). Elsewhere, direction from other bodies such as the Department of Health has also affected whether interventions are funded (Audit Commission 2005). These situations remain influencing factors.

A further limiting factor is that the changes required often involve a number of different stakeholders and, in some cases, substantial changes in local care pathways. Policy-makers frequently cite the need to adopt different ways of working and new models of care, reconfiguration of services, and improved working across professions (between primary and secondary care, with acute care and with outside agencies) as solutions to improving mental health outcomes. Although they increasingly consider the role and impact on individual stakeholder groups, few consider the necessary drivers and inherent complexities of implementation. Indeed, many of the recommendations made in previous reports on the future of mental health provision – such as the call for improved communication and collaboration between organisations – are themselves reflections of the underlying problems.

Leadership of this process is a key consideration, and one which has been highlighted as central to realising systemic change in London (Ham *et al* 2013). This includes addressing stakeholder involvement and leadership, both within organisations as well as across organisations. Ensuring corporate commitment and leadership from trust boards and senior managers not only impacts positively on organisational implementation but can have knock-on effects on commissioner decision-making and support (Mears *et al* 2008).

Findings from The King's Fund stakeholder engagement process

Our process of engagement highlighted a situation where the priorities and determination to improve the mental health outcomes of London was shared among the stakeholders, but the vision for achieving this was not.

A number of additional systemic barriers unique to implementing mental health provision in London were identified during this process.

The impact of political and historical agendas

Mental health was characterised as being politically and historically marginalised, with organisations having to fight for mental health to be prioritised. This approach



seems to have endured. As a result, many stakeholder groups demonstrated strong leadership, but were seen as driving forward change at the expense of working in partnership. This resulted in adverse consequences elsewhere in the system. The different historical agendas of groups were also seen as a barrier to finding solutions for moving forward. The challenge of bringing together social care solutions such as personalisation and independence and medically focused approaches was raised by a number of individuals. Some perceive that the unique power of each NHS mental health provider in London has contributed to this situation, both within and outside of the NHS. Despite significant changes in the structure of the NHS in recent years, many of these historical stakeholder relationships have remained unchanged.

Unconstructive communication between stakeholder groups

The political and historical agendas highlighted above led to considerable challenges in stakeholders working together. The relationship between stakeholders was characterised on a number of occasions by a lack of constructive communication that was both reported and witnessed. Many stakeholders either took the position that current problems should be solved by them taking the lead, or pointed the finger at other stakeholders for providing inadequate support for efforts to improve mental health in London. The NHS 'health' sector was seen to dominate as both the lead for provision and for potential solutions, and this created tension with other stakeholder groups. Underpinning this was a lack of shared knowledge around the agendas of different stakeholder groups and, importantly, limited knowledge and acknowledgement of what each group does well, what they can do, access to resources, and their strengths and weaknesses.

Volume of strategy and working groups

Throughout the course of the project we were made aware of a huge number of groups working on different strategies to improve London's mental health. Indeed, among academics, providers, service users, third sector, policy-makers, government, and commissioners, there is a sense that everyone seems to be doing something. Despite this, ownership of projects or a lack of initial scoping meant there was often limited joining up of work and alignment of strategies. Work being done in one sector was noted to require the involvement of, or impact on, other sectors; but several groups describe not being invited 'to the table', which has raised tensions. There is therefore likely to be a lot of unnecessary duplication of work, and unless the relevant organisations are consulted at an early stage, many strategies are unlikely to deliver the benefits envisaged.



Weak commissioning in mental health

Most stakeholders regarded the limited focus of commissioners on mental health and limited skills in commissioning mental health services as a key factor in creating many of the challenges facing providers in London today. Despite the new focus on commissioning, there is widespread belief that mental health is still not on the agenda with local authorities and clinical commissioning groups (CCGs), and there is distrust of their capacity and skill to commission mental health appropriately. Efforts to develop a new dialogue are limited by a lack of co-operative engagement and shared agendas. We found few examples of truly collaborative commissioning involving all stakeholders. In spite of this, many commissioners are forging ahead, often using consultancy to fill gaps in skills and knowledge. Although many local authorities are working alongside CCGs to improve the mental health of their populations, in practice different geographical boundaries, different priorities and inequalities in funding (with a lack of shared budgets) are reducing the ability to achieve shared solutions. It was rare that mental health was considered across areas under the remit of local authorities other than health.

Stakeholders and policy-makers agree that improving the mental health outcomes of London requires a range of interventions that will improve existing mental health provision, transform the model of service delivery from one of treatment to prevention, and extend the boundaries of mental health beyond health and social care to the community as a whole. This will require greater attention to integrated care pathways and integration of service provision with a systemic approach to implementation. The challenges of achieving this will require multiple stakeholders across different sectors to work together collaboratively. Achieving cross-system working in this way is a challenge that is being experienced more widely, with efforts to increase integration of service provision for people with long-term conditions. However, our engagement process has identified additional barriers that may make joint working particularly difficult to achieve within mental health.



8 Achieving the vision

Drawing on the findings of our stakeholder engagement process, and the literature on mental health service transformation, we propose a number of steps to facilitate the systemic changes required to deliver improved mental health and wellbeing outcomes in London.

Collaborative commissioning to facilitate strategic change

Given the role of funding in supporting and sustaining change, commissioners should be a key component in driving change. The development of a programme by NHS England to deliver support and training to clinical commissioning group (CCG) leaders in commissioning for mental health was piloted in London and is a valuable contribution to this priority. However, our analysis suggests that although CCGs have been established to take account of local needs, the evidence to support improvement in mental health outcomes – particularly in relation to the acute care pathway – is less locality-specific. As such, CCGs may benefit by increasingly working together across population boundaries. This would facilitate the sharing of resources and expertise, and create a better platform for engagement with NHS providers in order to design care pathways, identify appropriate outcomes and procure accordingly. Given the transient nature of London's population, this may additionally serve as a mechanism for ensuring continuity of care, maximising the allocation of resources to tackle inequalities across larger areas of London, and provide the capability to procure on volume to maximise cost-effectiveness.

Driving change through collective systems leadership

Although the issue of leadership has been raised in relation to achieving parity of esteem and systems transformation in mental health, this has mostly focused on the roles individual organisations and stakeholder groups should take in implementing change, as opposed to the role of leaders in supporting collaboration across the system. The number and diversity of stakeholders in mental health is unique, and work exploring the wider transformation of health care in London has highlighted the importance of establishing 'constellations of leadership' among different



stakeholder groups to drive implementation (Ham *et al* 2013). However, given the cultural and political barriers between stakeholder groups, and the impact of this on developing a shared plan of action, leadership culture is a key element in achieving progress.

An increasing number of collaborative systems of leadership are emerging to support health care improvement and transformation. One of the more established examples can be seen in Manchester, where commissioners and providers have long-standing arrangements for working together to support transformational change (Ham *et al* 2013). More recent examples include the Lambeth Collaborative in south London and the developing collaborative arrangements in west London. Each involves multiple stakeholders, including CCGs, primary care, mental health providers, service users and the local community. Organisations that are coming together to develop systemic solutions commonly describe a process of developing new ways of working that draw on core elements of collaborative leadership and systems leadership models. Both leadership approaches recognise the importance of starting the process by establishing a unifying agenda among the stakeholders, then working to develop not only pathways forward, but the behaviours, language and ways of working which support these.

A further part of this process is the management of the potential risks associated with collaboration. Recognising these risks and addressing them early – such as agreeing what information will be shared and how it will be used – is likely to promote relationships in which expertise and resources are shared in a mutually beneficial way to deliver an agenda of improved outcomes. This represents a relatively new approach to the development of mental health provision and, as such, stakeholders are likely to benefit from relevant support and training in building and maintaining these collaborative relationships.

Putting service users, carers and clinicians at the core of provision

At the heart of our engagement process were service users, carers and clinicians. The contribution they made to the stakeholder events was notable. Bringing everyone together as equals in a room and working through a process of facilitated discussion presented a unique opportunity to share experience, knowledge and perspectives. However, throughout our wider engagement, many service users and carers reported feeling insufficiently involved in decisions; where they were sufficiently



involved, they often felt their experience and opinions were not adequately valued and that they were not there on an equal basis. Clinicians also spoke out about not having been adequately consulted about developments in their area and having a lack of voice more widely.

The value of these groups in providing a unique perspective on what it is like to deliver and receive services on the ground cannot be overstated. A failure by commissioners, providers and policy-makers to effectively engage with each group, as individual organisations and in developing cross-organisational solutions, is likely to result in a system that delivers neither improved outcomes nor experience.

Contracting to integrate mental health

A significant proportion of the systemic change identified requires varying degrees of integration, from integrated pathways to the integration of services currently run by different providers, and in many cases different sectors. This is all the more important in mental health, where broad determinants of mental health play a key role in the development of illness, where support is often provided within community and third sector organisations, and where the identified need is to move towards a more population-based approach to prevention.

There are a growing number of examples of how contracting can support this process. Outcomes-focused tariff systems present a promising opportunity for developing integrated care pathways, and clustering activities involved in developing a national tariff system may support this. Alliance and lead-provider contracts are also proving to be an effective way of bringing stakeholders together to develop integrated solutions. Each benefits from requiring the engagement of other key stakeholder groups within a geographical area, including primary care, mental health care providers, acute care providers, the voluntary sector, service users and carers, and – perhaps most importantly – local commissioners, to develop a collaborative agreement in the provision of care pathways or defined outcomes. Commissioners can drive this process by identifying preferred models of provision (eg, integrated solutions).

Finally, although block contracts have, in part, contributed to poor integration and limited partnership working ([Mental Health Strategies 2012](#)), they should not be discounted in facilitating organisations to deliver improved outcomes; but doing



so requires appropriate transparency and use of meaningful outcomes to hold providers to account. Contractual incentives, including Commissioning for Quality and Innovation (CQUIN) payments and performance-related payments may also support delivery. In considering the value of each approach it is important to note that contracting to support integrated care is a developmental area, and in isolation is unlikely to deliver improved outcomes in mental health unless supported by the adoption of new ways of working.

Developing a public health approach to mental wellbeing

There is a growing body of evidence that highlights a requirement to support the wider public in developing and maintaining positive mental health and wellbeing. However, as an emerging area of endeavour, public mental health is an area in which there is the weakest evidence base and where there has been the least investment to date. Developing a public mental health approach will require a significant change of focus and investment by organisations in achieving measurable outcomes.

Our stakeholder engagement process highlighted the value of starting by examining the existing activities of stakeholders, in particular local authorities and CCGs, which have an impact on mental health and wellbeing and ensuring that relevant outcomes are measured. This may mean re-examining existing data sets to highlight how these outcomes impact on mental health. The unique role of Public Health England is important in supporting this and a greater focus on public mental health, but also in ensuring that where interventions are planned, they are evidence-based, cost-effective, and maximise outcomes. As such, Public Health England should play a core role in highlighting the value of public mental health, how improved public mental health outcomes can be achieved, and where there is an evidence base for intervention. Given the challenges of developing a population-based public health approach, our stakeholders concurred that joint commissioning agreements between local authorities and CCGs for mental health were valuable in ensuring a coherent strategy, managing differential funding agreements, and maximising the ability to put mental health on the agenda across both types of organisation.

Increasing impact through pan-London solutions

Although greater integration of mental health commissioning across CCGs and joint commissioning with local authorities is likely to support the delivery of



improved outcomes across regions of London, some areas of commissioning may be best supported by pan-London solutions. A number of areas of provision have arisen from our discussions where pan-London approaches are likely to maximise potential impact:

- *The development of population-based interventions to support mental health and wellbeing.* Health promotion approaches require sufficient exposure and penetration to attain a population-level impact (Merzel and D’Afflitti 2003). Furthermore, the ability to commission across London enables a scale of procurement by which cost savings could be achieved.
- *Implementation of section 136 protocols.* Currently, local protocols vary widely, which brings confusion between agencies and variation in service at a critical point when service users are at their most vulnerable. The Mental Health Partnership Board is reviewing current practice. A pan-London agreement would ensure a common standard of service.

Current efforts to achieve pan-London agreements and commissioning have proved challenging. The large number of organisations involved, particularly with regard to public health approaches, is a major challenge to getting unanimous agreements and even more so where each is required to part-fund strategies. Questions around the ability to sustain consensus and funding have also arisen. Our research suggests that the development of a mechanism to facilitate pan-London commissioning offers the best prospect of being able to develop pan-London strategies and drive forward change at scale and pace, and may include the development of a single London commissioning board. Given sufficient resources and support, such a body may in future be in a position to facilitate the role of NHS England in commissioning for mental health specialist services for London. However, it is important that the role of this body is clearly defined in order to avoid creating a strategic organisation deemed to be over-bureaucratic and costly.

Developing data to support improvement

Underpinning the commissioning and delivery of high-quality mental health provision to improve outcomes is the need for good data. The data available through the local observatories highlight that there is a large degree of variation in service provision and outcomes between different providers and different CCGs. However, there is a lack of clarity around what this means in practice and therefore an



inability to establish whether existing provision adequately meets the needs of the population.

We identified a number of issues that contribute to this. There is a dearth of meaningful outcomes-based metrics in mental health. Of the data available, some are defined historically but are no longer required or used, while in many places the outcomes required by commissioners are not matched by those collated by providers. Access to data is often problematic, with relevant data sets hosted by a range of different organisations; also, data are not made available in a format that is accessible without significant analytical input. Finally, many organisations use different measures for the same outcome, which limits the ability to compare and share outcomes. The absence of readily accessible data to define what the issues are, their impact and, importantly, what works in terms of models of care and delivery, presents a number of challenges: it leaves commissioners blind in their efforts to define provision, and limits the ability to demonstrate effectiveness and thus hold each organisation to account.

The Mental Health Intelligence Network tools may go some way to bringing these data together and supporting the wider use of outcomes data but organisations need to be cautious in creating data analyses that are overly complicated and, wherever possible, should aim to provide a clear indication as to where improvements can and should be made. Additionally, a central set of mental health and wellbeing outcomes should be developed to support standardisation of data where required. Given that only 25 per cent of people with mental health problems are in treatment ([Centre for Economic Performance's Mental Health Policy Group 2012](#)), it is important that this process is extended to ensure equivalent measurement across primary care, acute care, and social care where the broader determinants of mental health and recovery-oriented outcomes are also more amenable to capture. This may reduce the burden of data collection across individual sectors while maximising the availability of data on broader health and social care outcomes.

Building effective dissemination strategies

The large number of academic health science centres (AHSCs) and Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) in London put the capital at the forefront of innovation in England. This is further matched by a wealth of organisations focused on developing strategies to improve the mental health and



wellbeing of London's population. However, this often leads to local innovation occurring in isolation, initiated and led by a particular stakeholder group seeking to address an issue of local importance. In practice, this can mean that several similar initiatives occur across the capital at the same time; leadership by one stakeholder group can be at the expense of ensuring that all the right stakeholders are involved, and the impact of the innovation can remain local and, in many cases, unsustainable due to a lack of wider support. This activity can intensify the significant variation in provision across the capital.

It is clear, however, that work being undertaken in some areas of London could benefit other areas through shared learning and models. The London-wide coverage of AHSCs and academic health science networks (AHSNs) provides a mechanism for achieving this. As such, their remit needs to adequately reflect the importance of conducting both high-quality research and engaging with organisations within their locality to capture, evaluate and disseminate efforts to improve the mental health and wellbeing of London. Their engagement activities should incorporate and expand current methods of dissemination to maximise the involvement of key stakeholder groups, including commissioners, service users and carers, policy-makers and the wider public.

Creating a new narrative for mental health

Narratives that have been adopted to highlight issues in mental health have served to raise public awareness through initiatives such as Time to Change and have gained a number of prominent and influential advocates. However, we would argue that it is time to adopt new narratives in order to achieve further gains within the health and social care system.

The dominant narrative of 'mental health' contains a number of complexities. First, it captures not only mental illness, but also mental wellbeing – that is, an absence of mental illness. Second, the term 'mental illness' often comprises a number of different disorders with broad spectrums of severity. Both provide a challenge in communicating a single message. As such, mental health either has a propensity to get watered down or lost in a narrative of 'everything contributes to mental health', or excessive focus is placed on mental illness and secondary mental health services.



A focus on funding as a core element of the narrative also appears to have limited impact. The call for additional funding as a solution to the issues facing mental health and mental health services arises at almost every opportunity; however, there is a lack of consensus on priorities for funding, and within the wider health and social care economy this argument no longer appears to resonate. The differential tariff deflator applied to mental health is one example of this. It is also notable that while the NHS mandate for parity of esteem has garnered significant support from mental health organisations, it is somewhat marked by silence in the acute and social care sector. With no fairy godmother at hand, the ‘Cinderella’ service risks finding its calls unanswered and being permanently banished to the scullery.

Given the extent of the financial pressures that are being felt across health and social care services, this dominant narrative runs the risk of further isolating mental health services and providers, thereby limiting the improvements in outcomes it ultimately seeks to achieve. Our analysis suggests that mental health organisations may benefit from beginning to adopt emerging narratives more systemically to build support. One approach is to separate out the notion of public mental health and wellbeing from mental illness and mental health service provision, resulting in two distinct narratives – both focused on prevention of illness, but at different levels. A second approach is to embed mental illness within the broader narratives of long-term conditions. The evidence base that supports investment in long-term conditions in order to deliver improved outcomes is one which has garnered significant support in acute and social care and, importantly, with commissioning organisations. Our report into the development of community mental health services suggests that mental health organisations have a significant degree of expertise to share on this and on the patient leadership required (Gilburt *et al* 2014), yet mental health is rarely mentioned in the wider debate on long-term conditions. This expertise presents an opportunity to restate the case for mental health within the context of wider debates, identifying where integration may facilitate improved care, and in doing so may highlight underlying disparities in funding and outcomes.

Taking this forward: leading change

The process of stakeholder engagement highlighted a number of areas of good practice, where elements of the shared vision described are being implemented. It will be important to build on these examples, spreading both learning and



leadership. But stakeholders need to take the lead in bringing different groups together to develop shared agendas and plans of action.

Organisations such as Public Health England, NHS England, AHSNs, AHSCs and CLAHRCs are key to facilitating transformation, as they can provide an agenda and the requisite infrastructure to support change. However, it is commissioners and providers who are at the forefront of transformation, with each playing a vital and complementary role in convening stakeholders and developing systems of collaborative leadership. Our findings demonstrated that either grouping could be instrumental in achieving this, and that the provider role could include other sectors of the health service and providers outside of the NHS. While the initial leadership may come from particular stakeholder groups, the success of these collaborations will lie in the ability of all parties to engage constructively in the process and demonstrate their commitment to achieving positive change.



9 Conclusions

Improving mental health outcomes for London's population requires not just defining what needs to be done, but giving due consideration to how it will be achieved. Current approaches to the promotion of mental wellbeing, prevention of illness and delivery of effective treatment have facilitated examples of good practice across the capital, but the high degree of variation in service provision has limited the impact in terms of outcomes for people with mental health problems. London is not exempt from national critiques of mental health provision, nor are the priorities and expectations of its mental health stakeholders unique.

Efforts to improve mental health outcomes have provided a clear understanding of the issues, evidence to support delivery and a vision of the future, but they have rarely considered what underpins each. Our analysis has highlighted that discourses in mental health and ways of working that have evolved between stakeholders have not only contributed to limited progress to date but present a major barrier to future improvement.

Recognising this and reframing the issues provides a framework for identifying the changes required. On the ground, certain approaches can support improved integration of care and delivery of outcomes; these include adopting collaborative leadership strategies, capitalising on the inherent strengths of different stakeholder groups and the opportunities each brings to the table, and the effective use of contracting tools. The strategic dissemination of evidence and development of data and outcomes can further ensure that progress is systemic. Underpinning this is a need to challenge the siloed status of mental health conditions and provision through developing new discourses that focus not on its uniqueness but its ubiquity and the expertise that has been developed in identifying and addressing mental illness.

There is no doubt that faced with the reconfiguration of the health and social care playing field, there are many challenges ahead. However, in placing the spotlight on what needs to change and how, there is a window of opportunity for stakeholders to alter the trajectory of mental health and develop the foundations for a new wave of transformation that delivers parity of outcomes for the foreseeable future.



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Richard returned to the Department of Health in 2003 where he undertook a number of roles including Senior Economic Adviser, Director of Strategy, Director of Financial Planning and Chief Analyst, and finally Director of Finance, Quality, Strategy and Analysis. In 2013 he moved to NHS England as Chief Analyst before leaving to join The King's Fund.



Acknowledgements

This report received financial support from the London Mental Health Trust Chief Executives Group. We are grateful to Mind and Rethink Mental Illness for their support in facilitating the involvement of service users and carers in the stakeholder engagement process.

The views expressed in this report are those of The King's Fund and the authors.



Published by

The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2568
Fax: 020 7307 2801

Email:
publications@kingsfund.org.uk

www.kingsfund.org.uk

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First published 2014 by
The King's Fund

Charity registration number:
1126980

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ISBN: 978 1 909029 36 1

A catalogue record for this
publication is available from
the British Library

Edited by Kathryn O'Neill

Typeset by Peter Powell

Printed in the UK by
The King's Fund

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The government's mandate for achieving parity of esteem between physical and mental health has put the spotlight on mental health provision. It has created an opportunity for the main stakeholders in London to bring together their unique resources, capacities and expertise to address the mental health needs of its large, diverse and transient population. But can they overcome the enduring barriers to collaborative working and agree a shared vision of how to achieve systemic change?

Transforming mental health: a plan of action for London describes a vision for the future of mental health provision in London generated through a process of engagement with key stakeholders in the capital. It gives an overview of current knowledge and thinking about how to shape provision, identifies a number of priority areas agreed by stakeholders, and discusses the main challenges to effective implementation of the vision.

The report concludes by proposing a number of steps to facilitate systemic change including:

- developing processes for collaborative commissioning
- driving change through collective systems leadership
- ensuring that service users, carers and clinicians are at the core of provision
- using contracting systems to support integration
- building a public health approach to mental wellbeing
- developing pan-London solutions to increase impact
- improving the availability of meaningful outcomes data
- utilising London's academic infrastructure to disseminate best practice
- creating a new narrative for mental health.

Delivering this shared vision for London's mental health requires the many and diverse stakeholders involved to adopt a different approach and develop truly collaborative solutions. In the face of finite resources, failure to take advantage of this opportunity may further marginalise mental health provision in the capital. But by adopting a clear, shared agenda for improving the mental health outcomes of Londoners, and working together to implement it, stakeholders could once again put mental health transformation centre stage.

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Charity registration number: 1126980

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ISBN 978-1-909029-36-1



9 781909 029361