Public Bill Committee: Health and Care Bill Evidence submission

Royal College of Psychiatrists

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Introduction

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom. We work to secure the best outcomes for people with mental illness, learning difficulties and developmental disorders by promoting excellent mental health services, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry.

As we emerge from the Covid-19 pandemic we know that supporting the nation's mental health will be more important than ever. The reforms proposed through the new Health and Care Bill have the potential to significantly improve the care provided to people with mental ill health. The focus on partnership and integration could lead to better coordinated and more effective care, and stronger relationships between health and care partners to support this.

Integrated Care Systems (ICSs) can learn from the mental health care sector due to its experience in developing and embedding integrated approaches to service delivery, joint commissioning, co-production, and working closely with the voluntary sector and local government.

Mental illness is on the rise, and has been a major concern throughout the pandemic. Mental health problems are one of the most significant causes of disability in England, affecting one in five mothers during pregnancy or in the first year after childbirth, one in eight children and young people and one in six adults[1]. Our mental health can be deeply affected by the social determinants of health and our environment[2]. A population health-based approach is core to ICS planning and decision making, and mental health is a key population need across the country.

[1] Royal College of Psychiatrists. 2020. *Next Steps for Funding Mental Healthcare in England: A Comprehensive Settlement That Invests In Infrastructure, Prevention, People And Technology*. Accessed at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/next-steps-for-funding-mental-healthcare-in-england-full-report---24-9-20.pdf

[2] Alegría M, NeMoyer A, Falgàs Bagué I, Wang Y, Alvarez K. 2018. *Social Determinants of Mental Health: Where We Are and Where We Need to Go*. Curr Psychiatry Rep. Published 2018 Sep 17. doi:10.1007/s11920-018-0969-9. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6181118/

In consultation with members and partner organisations, and on reviewing relevant evidence, we have developed initial suggestions for strengthening the Health and Care Bill to ensure a stronger legal foundation for parity of esteem between mental and physical health, to reduce mental health inequalities, to support collaboration with patients, carers and the voluntary and community sector (VCSE), and ensure we have the right healthcare workforce.

In summary, our proposals for strengthening the legislation comprise the following suggested amendments:

1. A new duty for Integrated Care Boards (ICBs) to promote parity of esteem between mental and physical health.
2. A requirement for a mental health representative on every ICB so that the needs of patients with a mental illness are not forgotten.
3. Rewording of the ICB duty on quality of services to give equal consideration to mental and physical illness.
4. A requirement for the Secretary of State to, at least once every two years, report independently verified workforce supply and demand projections.
5. A requirement for ICBs to implement systems to identify and monitor inequalities in mental and physical health.
6. Strengthening the legislation to support collaboration with patients, carers, and the VCSE sector.

Ensuring parity of esteem between physical and mental health

Mental illness represents up to 23% of the total burden of ill health in the UK but only 11% of NHS England's budget[3]. As we emerge from the Covid-19 pandemic and proposals are developed for restructuring of the NHS, the opportunity to address this shortfall in resourcing and prioritisation must be taken.

The mental health impacts of the pandemic have been stark, and even pre-pandemic, levels of mental illness were rising overall. In March 2021, there were more than 400,000 referrals to mental health services - the highest ever recorded in a calendar month. There were 404,552 referrals reported in March 2021, which is 36% up on the pandemic-impacted March 2020 and 26% up on the pre pandemic March 2019[4]. Modelling from the Centre for Mental Health suggests that an additional 10 million people may need mental health care as a result of the pandemic[5].

[3] The Kings Fund. 2015. *Has the government put mental health on an equal footing with physical health?* Accessed at: https://www.kingsfund.org.uk/projects/verdict/has-government-put-mental-health-equal-footing-physical-health

[4] NHS Digital. 2021. *MHS32*. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics

[5] Centre for Mental Health. 2020. *Covid-19 and the nation's mental health: October 2020*. Accessed at: https://www.centreformentalhealth.org.uk/news/10-million-people-england-may-need-support-their-mental-health-result-pandemic-says-centre-mental-health

Funding made available via the Long Term Plan is welcome, but it alone will not address the huge challenges facing the mental health care system in England. We must be realistic about rising demand as a result of the pandemic, as well as the backlog to be worked through, and enable mental health services to meet patient needs.

As we learn more about mental illness and its impact on our health, the historic imbalance in prioritisation between efforts to provide physical and mental health care become clear. Although we have made significant progress on parity of esteem, the legacy of this imbalance is still pervasive. Through a recent survey we found that 63% of responding psychiatrists felt that their local area had been ineffective in working towards parity of esteem. Less than one in ten said their local area was effectively promoting parity of esteem[6].

As the Bill sets up the new legal structures for the NHS, it is vital that we don't repeat the mistakes of the past. The Bill needs to go further on mental health to make sure ICSs are considering mental health as well as physical health in their decision making.

<u>RECOMMENDATION 1:</u> A new duty should be added for ICBs to 'Promote parity of esteem between physical and mental health', and to demonstrate work toward this through forward planning and annual reports

- Every ICB should be required to promote parity of esteem. It should be included in their 'forward plans' and they should be required to report on it as part of their annual reports. This would increase transparency and help hold the system to account.
- This should not create extra burdens or be a box ticking exercise because NHS England and NHS Improvement already require annual information on how local areas are progressing against national plans to improve care for people with a mental illness, including information on waiting times and patient outcomes. This would largely involve making this information public within the ICB annual report.

Proposed amendment
Part 1, page 18, line 25 insert new clause –
Duty to promote parity of esteem between mental and physical health

Each integrated care board must have regard to, in the exercise of its functions, the equal importance of mental and physical health
Proposed amendment
Clause 14Z50, page 21, line 12, at end insert –
Section [insert new clause on duty to promote parity of esteem between mental and physical health] Duty to promote parity of esteem between mental and physical health

[6] Royal College of Psychiatrists. 2021. *Research Panel survey findings 2021*. Survey data available on request.

Member's explanatory statement
This amendment would require the joint forward plans for integrated care boards and their partners to include a description of how they plan to meet their duty to promote parity of esteem between mental and physical health
Proposed amendment
Clause 14Z56, page 24, line 30, at end insert –
Section [insert new clause on duty to promote parity of esteem between mental and physical health] Duty to promote parity of esteem between mental and physical health
Member's explanatory statement
This amendment would require the integrated care board annual reports to include a review of what they have done to to meet their duty to promote parity of esteem between mental and physical health

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RECOMMENDATION 2: A mental health representative must be mandated on the ICBs, in addition to the current minimum membership

- The current wording of the Bill and the guidance published by the NHS means it will be possible for some areas to have no mental health representation on the ICB. We share the concerns of NHS Mental Health Trusts[7] that not having a mandated representative would be a backwards step for parity of esteem for mental health and may mean resources are diverted away from mental health services.
- While individuals within the current proposed board membership may have some experience of mental health, and will have engaged with mental health providers to seek their views, specialist mental health expertise will be needed. Without it, there is a risk that a significant proportion of healthcare need across the locality will not be fully understood and provided for in decision-making.
- Furthermore, as the ICS Design Framework has clearly set out, ICS NHS boards will have responsibility for funding decisions on several key aspects of population care, including mental health and the meeting of the Mental Health Investment Standard.
- The RCPsych recently surveyed 120 members in England who were asked about the local involvement of mental health providers in ICS decision-making. 42% of respondents sadly felt it was either 'very poor' or 'poor', with only 15% rating it good or very good.

Proposed amendment
Schedule 2, Page 120 line 14 leave out subsection (a) and insert:
"(a) one member nominated jointly by the NHS trusts and NHS foundation trusts that—
(i) provide services for the purposes of physical healthcare within the integrated care board's area, and

[7] Mental Health Network. 2021. *Mental health trusts call for guaranteed representation on ICS NHS boards.* Accessed at: https://www.nhsconfed.org/publications/mental-health-trusts-call-guaranteed-representation-ics-nhs-boards

(ii) are of a prescribed description;
(b) one member nominated jointly by the NHS trusts and NHS foundation trusts that—
(i) provide services for the purposes of mental healthcare within the integrated care board's area, and
(ii) are of a prescribed description;"
Member's explanatory statement
This amendment would require Integrated Care Boards to have members representing trusts whose primary responsibility is for mental health care as well as trusts whose primary responsibility is for physical healthcare.

RECOMMENDATION 3: The ICB 'Duty as to improvement in quality of services' (14Z34) should include reference to mental health

- In keeping with efforts to promote parity of esteem and ensure that mental health services are not under-prioritised as has historically been the case, we recommend the explicit inclusion of mental illness in the duty to improve healthcare services on an ongoing basis.
- As ICBs must report on this duty, we believe the explicit inclusion of mental illness will stimulate efforts to improve mental healthcare.
- While the Bill specifically clarifies that when it refers to health care it means mental and physical health, there is no similar clarification for illness. This could, therefore, create an unintended loophole and miss an opportunity to remind ICBs of their duties for people with mental illness.
- We believe not having this would be a backwards step considering the Health and Social Care Act 2012 was amended to ensure that mental health was specifically referenced in the duties of the Secretary of State[8]. This has commonly been seen as creating a legal duty to work towards parity of esteem at a national level. This law has been one of the key drivers to ensure the NHS does not forget about mental health and it is vital that this new law replicates the same language at a local level.

Proposed amendment
Part 1, Page 16, line 12 after "of" insert "physical and mental"
Member's explanatory statement
This amendment would require integrated care boards to work towards improving the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of mental illness as well as physical illness.

[8] UK Government. 2012. *Health and Social Care Act 2012 - Part 1*. Accessed at: https://www.legislation.gov.uk/ukpga/2012/7/section/1

Ensuring we have the right NHS mental health workforce

In the mental health sector, recruiting enough skilled staff to meet the needs of patients is an urgent challenge. To overcome this challenge, the Five Year Forward View for Mental Health and NHS Long Term Plan both included indicative workforce requirements to deliver service ambitions. However, the numbers required for the Five Year Forward View for Mental Health have not been met, and the numbers required for the NHS Long Term Plan are not on track to be met. This means that an insufficient workforce remains widely recognised as one of the biggest risks to delivering national ambitions to improve mental healthcare[9].

For example, in the plan to deliver the Five Year Forward View for Mental Health[10] – Stepping forward to 2020/21: The mental health workforce plan for England[11] – the Government set a target to employ 570 more consultant psychiatrists and 8,100 mental health nurses by March 2021. This deadline has now passed and there has been a complete failure to expand the mental health workforce. By March 2021, the NHS only filled 210 out of the target 570 (37%) consultant psychiatrist posts and 3,010 of the target 8,100 (37%) mental health nurses[12]. Furthermore, the NHS Long Term Plan is meant to build on the planned workforce set out in the Five Year Forward View, yet as of May 2021 we were around 390 consultant psychiatrists behind the target for 2020/21[13], and therefore on course to miss the LTP target by 2023/24.

In part, this is because workforce planning has come too late in the planning cycle. For example, the workforce plan for the Five Year Forward View for Mental Health was published over a year later. It is also due to short-term workforce planning that fails to understand the length of time it takes to train staff, which is evidenced by two one-year People Plans that do not align with the workforce targets required to implement the Long Term Plan. To-date, there has also been no transparent attempts to sufficiently compare workforce supply against workforce demand meaning that persistent workforce shortages remain a reality.

The increase in vacancies is only making matters worse. Our 2019 Workforce Census showed that the number of vacant consultant posts across England more than tripled from 220 in 2013 to 708 in 2019, which resulted in 10% of all consultant psychiatrist roles being unfilled[14]. More recent data from the fourth

[9] The Health Foundation, The King's Fund and Nuffield Trust. 2018. *The healthcare workforce in England.* Accessed at: https://www.kingsfund.org.uk/sites/default/files/2018-11/The%20health%20care%20workforce%20in%20England.pdf

[10] NHS England. 2016*. Implementing the Five Year Forward View for Mental Health.* Accessed at: https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

[11] Health Education England. 2017. *Stepping forward to 2020/21: The mental health workforce plan for England.* Accessed at: https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf

[12] NHS Digital. 2021. *NHS Workforce Statistics - March 2021*. Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/march-2021

[13] NHS Digital. 2021. *NHS Workforce Statistics – May 2021.* Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/may-2021

[14] The Royal College of Psychiatrists. 2019. *Census 2019.* Accessed at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/census-final-update060720-1.pdf?sfvrsn=bffa4b43_8

quarter of 2020/21 showed a total of 16,660 WTE vacancies across the mental health workforce. Of those, 1,215 were for medical posts and 8,388 for nursing posts, which equates to 58% of total vacancies[15].

The Health and Care Bill presents an important opportunity to address historical issues relating to a lack of long-term workforce planning, yet the current provisions are inadequate. A report every five years which sets out roles and responsibilities for workforce planning will fail to provide the transparency and accountability that is required to deliver the workforce that we need.

Alongside several other organisations[16][17], we have previously called for a duty to mandate the government to publish regular independently verified workforce supply and demand projections. The Health and Social Care Committee also recommended the publication of reports on workforce shortages and future staffing requirements covering the next 5, 10 and 20 years[18].

With rising demand for mental health services due to the pandemic, it is more important than ever to address workforce shortages once and for all. The Office for Budget Responsibility (OBR) already predicts likely health care spending, by projecting likely healthcare activity, considering demographic changes and other factors such as the changing cost of healthcare and likely impact of technology and rising prevalence of certain health conditions. The Government is well-versed in using the expert guidance of OBR to inform decision making, and so we urge that workforce demand assessments are based on OBR projections (and the assumptions tied up in them) so that services can be planned in the knowledge that the workforce will be there to deliver it.

<u>RECOMMENDATION 4:</u> The Secretary of State should, at least once every two years, report independently verified workforce supply and demand projections

- The current provisions in the Bill provide no clarity as to whether the system is training and retaining enough people to deliver services both now and in the future.
- To ensure that we have the staff numbers required to deliver the work that the OBR estimates we will need to carry out in future, we recommend the biannual publication of a report that sets out:
    - Workforce numbers at the time of publication and projected supply for the following 5, 10 and 20 years

[15] NHS Digital. 2021. *NHS Vacancy Statistics England April 2015 - March 2021.* Accessed at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2021

[16] Academy of Medical Royal Colleges. 2021. *Letter to SoS Health and Social Care on workforce planning.* Accessed at: https://www.aomrc.org.uk/wp-content/uploads/2021/04/150421_Hancock_SoS_letter.pdf

[17] Nuffield Trust, The Health Foundation and The King's Fund. 2021.*The NHS Bill must put in place a system to support better workforce planning.* Accessed at: https://www.health.org.uk/news-and-comment/news/the-nhs-bill-must-put-in-place-a-system-to-support-better-workforce-planning

[18] Health and Social Care Committee. 2021*. The Government's White Paper proposals for the reform of Health and Social Care.* Accessed at: https://committees.parliament.uk/publications/5827/documents/67112/default/

    - Future workforce numbers based on the projected health and care needs of the population for the following 5, 10 and 20 years
- While this will not solve the workforce crisis, it will give us the best foundations to take long-term decisions about workforce planning to keep up with population need. It should, therefore, be used to inform local and regional training and recruitment needs, as well as underpin national recruitment and retention strategies.

Proposed amendment

Part 1, Page 40, line 6 leave out subsection (1) and (2) and insert:

"(1) The Secretary of State must, at least once every two years, lay a report to parliament describing the system in place for assessing and meeting the workforce needs for the health, social care and public health services in England.

(2) This report must include:

(a) an independently verified assessment of health, social care and public +projected supply for the following 5,10 and 20 years

(b) an independently verified assessment of future health, social care and public health workforce numbers based on the projected health and care needs of the population for the following 5, 10 and 20 years, consistent with the Office for Budget Responsibility long-term fiscal projections

(3) NHS England and Health Education England must assist in the preparation of a report under this section.

(4) The organisations listed in subsection (3) must consult with health and care employers, providers, trade unions, royal colleges, and any other persons deemed necessary for the preparation of this report, taking full account of workforce intelligence, evidence and plans from local organisations and partners within integrated care boards"

Member's explanatory statement

This amendment would require biennial published assessments of the workforce numbers required to deliver the work that the Office for Budget Responsibility estimates will be carried out in future, based on projected demographic changes, the growing prevalence of certain health conditions and likely impact of technology.

Ensuring mental health inequalities are addressed

There are inequalities within mental health that are varied and pervasive and affect access to services, experiences of care and ultimately, outcomes for people with mental illness. Although data on this issue is patchy, from the data that is available, there are some stark disparities which demonstrate the need for more focus and action.

For example, in the year to March 2020, Black people were more than 4 times as likely as White people to be detained under the Mental Health Act[19]. LGBT people are at increased risk of common mental illness, and still experience discrimination in healthcare settings, with many avoiding seeking healthcare for this reason[20]. People with disabilities experience poorer recovery outcomes in IAPT services than those without a disability[21], and people in lower income households are more likely to have unmet mental health treatment requests compared with those in the highest income households[22].

The examples above, and many more, indicate that increased action on and accountability for addressing mental health inequalities, and indeed all health inequalities, is needed across the system. Although we welcome the proposals for all ICBs to have a clear duty to reduce health inequalities in access to and outcomes from services in their area, we are concerned that there is no significant change from the duties on Clinical Commissioning Groups (CCGs) currently in place as a result of previous legislation.

We would therefore urge the bill is strengthened with clearer and more direct requirements on the need to design and commission services that reduce inequalities. As we understand it, often data isn't of enough volume or quality to be fully disaggregated across different protected characteristics and therefore provide a comprehensive insight into inequalities that exist.

One way the current duties could be strengthened is through more prescriptive legislative measures to ensure local systems are proactively identifying and monitoring health inequalities across their area. There is already national level infrastructure in place to support this across many areas, but localities must further drive quality data input and put in place improved mechanisms to understand and act on what local data is showing. This should include improving data collection on access to and outcomes from health services and could also include assessing wider inequalities in the local area in relation to areas such as public health or the local NHS workforce.

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[19] UK Government. 2021. *Detentions under the Mental Health Act.* Accessed at: https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest

[20] NHS England. 2020. Advancing mental health equalities strategy. Accessed at: https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

[21] NHS England. 2020. Advancing mental health equalities strategy. Accessed at: https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

[22] NHS England. 2020. Advancing mental health equalities strategy. Accessed at: https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf

We also recommend that mental health services should use the Advancing Mental Health Equalities toolkit to help them meet these duties when it comes to the commissioning and provision of mental health services.

RECOMMENDATION 5: The ICB Duties 'as to reducing inequalities' (14Z35) include the requirement to implement systems to identify and monitor physical and mental health inequalities between different groups of people within the population of its area.

- Data on health, and particularly mental health, inequalities is widely acknowledged to be substantially insufficient.
- We believe the infrastructure, supported by NHSEI, to be able to mandate local data collection to identify where local inequalities exist and monitor any changes is a vital precursor to targeted service improvement and evaluation.
- Therefore we would recommend that the duties as to reducing inequalities are expanded to include this critical element.

Proposed amendment
Part 1, Page 16, after line 28 insert:
"(c) implement systems to identify and monitor inequalities in physical and mental health between different groups of people within the population of its area"
Member's explanatory statement
This amendment would require integrated care boards to set up systems to identify and monitor inequalities in physical and mental health between different groups of people within the population of its area.

Engagement of patients and carers, and collaboration with the VCSE sector

Co-production is an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them. Collaborative efforts should represent the diversity of the local population in planning and decision making, to help ensure services are accessible and appropriate for different communities. Co-production has been shown to provide considerable benefits to services and patients[23].

The legislation in its current form includes a duty on ICBs to *"involve individuals to whom services are being provided or may be provided"* however systems should go further than simply consulting or providing information to patients, and this is already considered good practice in many areas. Models of commissioning of health services across the country have been moving toward a

[23] National Collaborating Centre for Mental Health. 2019. *Working Well Together.* Accessed at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/working-well-together/working-well-together---evidence-and-tools-to-enable-co-production-in-mental-health-commissioning.pdf?sfvrsn=4e2924c1_2

model where patients and carers are not only consulted on, but help to design and evaluate services.

As *'Working Well Together: evidence and tools to enable co-production in mental health commissioning'* from NHS England and the National Collaborating Centre for Mental Health sets out:

"The NHS Constitution for England holds public ownership in high esteem, declaring that the NHS is accountable to the public and that those who may need to use NHS services should be involved in their development and improvement. In addition, the Children Act 2004, 8 Health and Social Care Act 2012, 9 Care Act 201410 and NHS England's Patient and Public Participation Policy all require CCGs, local authorities and NHS England to embed public involvement and consultation in the commissioning of health services. Section 3.2 discusses levels of participation in coproduction in England; although these efforts rarely reach the level of genuine co-production, they provide a strong foundation and tradition on which to build."

As stated above, the current infrastructure around patient and public involvement provides a foundation which can be built upon. We recommend that work is undertaken with patient and carer groups to explore how the current bill can be strengthened to achieve this, with the potential for amending the duty on *'Public involvement and consultation by integrated care boards (14Z44)'* to embed an approach to service design that includes co-production.

Furthermore, VCSE organisations and their workforce play a vital role in supporting people with a mental illness, and they will be key players in helping the system address the increase in demand for mental health support. They also bring a wealth of expertise and insight about the needs of their local population, including groups underserved by statutory services. VCSE organisations are also often NHS partners and providers of services, and so their contribution should be recognised and their voice included in ICS planning and decision-making.

<u>RECOMMENDATION 6:</u> Legislation is strengthened to enable more comprehensive collaboration with patients and carers in designing and evaluating healthcare services, and also further collaboration with the VCSE sector.

- Co-production has been shown to benefit services and patients.
- If ICSs are to fulfil their duties on health inequalities, it is crucial that people who represent local populations are afforded a meaningful role in planning and decision making.
- The VCSE sector plays a critical role in supporting those with mental illness, and should be included in ICS planning and decision making.

We have not proposed a specific amendment for this issue, as we feel others may be better placed to explore and propose this.

For further information regarding this evidence submission, please contact Jonathan Blay, Public Affairs Manager, at Jonathan.blay@rcpsych.ac.uk or Rosanna Flury, Policy Engagement Manager at rosanna.flury@rcpsych.ac.uk