

2019

Improving mental health services in systems of integrated and accountable care: emerging lessons and priorities

Executive summary

Nothing stands still. Not the NHS, not the people we treat or the communities they live in, not the staff or the many organisations who we work with.

While the NHS continues to evolve, all areas are being challenged to become “Integrated Care Systems” (ICSs) by 2021, with the aim of health and care organisations working together more closely in a “pragmatic and practical” way. This will involve complex changes including to contracting and funding flows.

Changes to “behind the scenes” of the health and care system is not something that most people who interact with these services will be aware of, and nor should they be.

Patients have no need to keep up with the latest health service acronyms. The only change they should be aware of is receiving better, more joined up care, which people with mental illness could stand to benefit most from.

This evolution is likely to change how care is delivered across England and brings opportunity for mental health services to be incorporated more fully with the wider health and care system rather than being unhelpfully annexed, with patients’ care often disjointed and partial as a result.

As ICSs will focus on prevention as much as treatment, there is a key opportunity for NHS organisations, local councils and other system partners to make progress in reducing morbidity and mortality rates for people with severe mental illnesses, as well as improving patient experience and reducing unmet need.

I’m proud that mental health services have made remarkable improvements to the availability and quality of services provided to patients in recent years, and of the strong track record of the leaders of these services to deftly work across complex systems and to innovatively redesign and adapt.

But mental health services remain under exceptional operational, workforce and financial challenges and have often been relegated to the side lines of local area planning. Our patients can suffer as a result.

So while health services are systematically reviewed and re-configured as ICSs develop, it is essential that the voices of mental health services and their patients are heard, and not diluted or fragmented, in order to stay on track towards the end goal of delivering better, seamless care. The very existence of mental health trusts is because of a time when mental health services, and the needs of their patients, were drowned out by the acute sector. We cannot move back to that in the name of integration.

This guide aims to understand the priorities and lessons for improving mental health services in established and emerging ICSs and makes recommendations that reflect the opportunities and challenges for areas in doing so. I am particularly grateful for the time and patience of people working in the local areas who have shared their highs, lows, and everything in between.

There will be no end to this evolution, so I am in no doubt that these messages of advice will evolve and adapt along the way. I do hope that this provides a useful framework for local areas at this point in their evolution and that our recommendations to national bodies are acted on to enable this.

A handwritten signature in black ink that reads "Dr Adrian James". The signature is written in a cursive, slightly stylized font.

Dr Adrian James
Registrar, Royal College of Psychiatrists

Introducing any new model of care is likely to significantly change the delivery of care locally. As new models aim to reduce the divides between primary care, community services, social care, mental health services and hospitals, there is an opportunity to integrate mental health comprehensively into the wider health system. This report seeks to understand these opportunities, what the challenges are and provide advice on how they can be maximised.

Through a combination of research, policy analysis, site visits and interviews, this report aims to better understand the priorities and lessons for improving mental health services in established and emerging ICSs and make recommendations that reflect the opportunities and challenges in doing so. Case studies (Appendix 8 of the full document) illustrate the breadth of changes happening across the country. The full report also reflects on similar moves towards integrated and accountable care from the United States, Scotland and Wales.

As ICSs and STPs are continually evolving, we recognise that further lessons and priorities will emerge as more ICSs are established and progress across the country.

To read the full report and keep up to date with RCPsych's work on this area visit: <http://www.rcpsych.ac.uk/mental-health-ICS>

Policy context

The NHS faces a major challenge of delivering good care through the cost-effective use of resources; reducing unwarranted variation in outcomes, quality and safety; and working to prevent disease.

To achieve this 'triple aim', breaking the traditional divide between primary care, community services, mental health services and hospitals, and taking full accountability for population health outcomes, is necessary.¹ As well as NHS organisations, local authorities and the voluntary sector have a key role in promoting wellbeing and improving mental health in their communities.

One of the core groups that stand to benefit most from health system reform are people living with mental illnesses, and alcohol and substance use disorders; given the associated impact on quality of life, morbidity and mortality. Mental illness remains one of the largest single causes of disability in England² but two-thirds of people do not have access to evidence-based treatment³, and the College has argued that mental health has not been sufficiently prioritised in healthcare planning at a local level.⁴

The 2014 *Five Year Forward View*, set a strategy for achieving the 'triple aim', including forming Sustainability and Transformation Partnerships (STP) – collaborations between health and care organisations across England.⁵

In 2017, NHS England encouraged advanced STPs to evolve into Integrated Care Systems (ICS). ICSs bring together local organisations in a pragmatic and practical way to deliver 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. The *NHS Long Term Plan* went further and called on all STPs to become ICSs by April 2021 with funding flows and contract reform, underpinned by population-based new models of care to support the move.⁶

The case for change – increasing demand and the capacity and capability of services

ICSs have a clear role in ensuring system partners – NHS organisations, local authorities and the voluntary sector – address mental health need through population health management approaches and reduce unwarranted variation in service provision.

The increasing population size (forecast to grow by 5.9% in England) and incidence of mental health problems will lead to greater demand across public, independent and third sector services.⁷

Improving care for vulnerable populations, and those who have complex health and care needs (such as older adults and the very old), is critical. For example, we expect:

- more children and young people in the population will require an increased capacity for child and adolescent mental health services (CAMHS), parenting programmes, self-harm, substance misuse and criminal justice liaison services
- more people aged 30–45 will increase demand for Improving Access to Psychological Therapies (IAPT), maternal wellbeing, workplace wellbeing and early intervention service
- more older adults, including the very old, will increase the need for capacity in dementia, old age psychiatry and social care support services.

ICSs will also need to assess the use of healthcare resources across a system that goes beyond their individual organisation. For example, we know that adult and older adult mental health service users utilise acute emergency services disproportionately.

Despite the prevalence of mental illness, two-thirds of people do not have access to evidence-based treatment, people with severe mental illnesses die 15-20 years earlier than the rest of the population, and there is a significant gap in life expectancy for mental health service users when compared with the rest of the population. Users of specialist mental health services are more likely to die from any physical health causes than the population who do not require specialist mental health support and management.

Three years into the Five Year Forward View for Mental Health, there have been remarkable improvements in the availability and quality of mental health services (particularly children and young people's eating disorder services, perinatal services and IAPT), as well as the introduction of the first waiting time standards for mental health.

But mental health services are at a critical point and under exceptional operational, workforce and financial challenges. While the Long Term Plan seeks to shift towards a longer term planning process, some of the building blocks that underpin these policy changes, such as funding, workforce and data, may remain susceptible to in-year planning and operational changes.

ICS leaders have an opportunity to consider the challenges across the tiers of the local health system (at neighbourhood, place, system and regional levels). They provide an important opportunity to integrate mental health services within primary, acute, urgent and emergency care and social care.

As the introduction of any new model of care is likely to significantly change the delivery of care in an area, it is essential that mental health is considered at the beginning of the process.

Ultimately, the development of ICSs need to help solve these well-established, large-scale challenges. At a local level, examples of successfully doing so would be:

- minimal or no inappropriate out-of-area placements (OAPs) for acute inpatient treatment or rehabilitation
- delivery of integrated whole system care across different types and tiers of services for complex conditions such as dementia and for people with learning difficulties
- a workforce that meets the demand for mental health services, is fully valued and supported, and is easily working in multidisciplinary teams to deliver high quality care
- developing culturally competent mental health services with full engagement across minority groups.

Mental health in Integrated Care Systems

The full report describes in detail some of the changes happening across local health systems and the impact on the mental health of the population, including approaches to population health management and contractual models for greater cooperation and integration.

Population health management aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities by focusing on the wider determinants of health and the role of people and communities.⁷ ICSs need to strengthen the way NHS organisations work with local authorities and the voluntary sector to deliver effective action in this area, based on best practice.

North East London STP provides a good example of an area working to embed mental health into population health management.⁸ This involves linking patient-level data from acute services, primary medical care, social care, mental health, community services and continuing health care, which enables leaders to accurately assess how mental health conditions impact on activity and costs across the system.

To date, local leaders have taken a variety of approaches in terms of contractual models for greater cooperation and integration, including provider alliances, provider collaboratives, integrated care provider contracts and simply working more collaboratively. The NHS Long Term Plan Mental Health implementation plan sets the direction for the specialised commissioning mental health budget to be increasingly devolved to providers in NHS-led provider collaboratives. A target for all appropriate specialised mental health services, and learning disability and autism services, to be managed through NHS-led provider collaboratives by 2023/24 has been set.

Provider collaboratives are where similar NHS trusts, such as mental health trusts, come together to form a partnership to deliver health services to a wider population. These partnerships often bring together clinical expertise, experience and innovation, aiming to improve quality, use resources most effectively, and deliver best practice consistently to all patients. Examples include the South West Regional Secure Services, which sees

Devon Partnership NHS Trust as the accountable provider, leading eight organisations to commission and deliver medium and low secure mental health services for adults. West Yorkshire and Harrogate Health and Care Partnership have also come together to form a provider collaborative to ensure consistent outcomes for people accessing services based on integrated and standard operating models for acute/specialist mental health services.

A consequence of the spread of ICSs is the systematic review and reorganisation of health services. As such, mergers and acquisitions are also occurring. This can mean two or more NHS trusts come together to form a single organisation. They might then sub-contract services outside of their scope to other trusts. Alternatively, two mental health trusts might merge to improve their financial and clinical viability across their area.

Opportunities and challenges for mental health leaders

From our research, policy analysis, site visits and interviews, we have distilled the opportunities and challenges for mental health leaders into seven key themes with corresponding advice for local and national leaders.

The recommendations are designed to support prioritisation of mental health as ICSs develop over the next 12-18 months, taking account of the variable change of pace in different areas and the importance of evaluating and learning in real time. The advice and recommendations should be considered in conjunction with the guidance provided by NHS England, particularly:

- [Designing integrated care systems \(ICSs\) in England](#)
- [NHS Long Term Plan Implementation Framework: system support offer](#).

Other helpful national, regional and local guidance is likely to be produced in the coming months, such as Healthy London Partnership's [Mental Health in ICS Implementation Tool](#).

Key theme 1: Purpose and role of ICSs

- ICSs provide real opportunity to improve and join up mental health services with the rest of the health and care system. But there is a risk that ICS leaders' attention will be drawn to organisational and governance structures with not enough focus on improvements in patient care. ICSs need to improve outcomes that matter most to patients.
- As well as being the vehicle used to deliver the mental health commitments from the *Five Year Forward View for Mental Health* and the *NHS Long Term Plan*, ICS leaders should also think in an innovative way about mental health and act as exemplars for the rest of the system.
- The ICS model needs to create an opportunity to work in partnership with others in ways local leaders would not be able to do otherwise.
- ICSs provide opportunity to build wider system resilience when under strain from unmet need and unexpected demand.
- The purpose and focus of ICSs must be regularly reviewed.

Recommendations for national bodies:

Capture learning and share best practice

- NHS England & NHS Improvement should systematically capture and share learning from ICSs furthest ahead, including governance arrangements, workforce plans and service models (specifically including mental health), to support and accelerate progress in other areas and provide clarity on what is permissible and effective within the current legal framework.
- NHS England & NHS Improvement and Public Health England should require all 'Healthy New Towns' to report on their progress to promote mental health and wellbeing (amongst other priority areas) annually and take action accordingly.
- By spring 2020, NHS England & NHS Improvement to share annual GIRFT reports on mental health with ICS leaders.
- Mental health trusts exceeding core expectations in ICSs should work with those who are struggling through a peer-learning approach, beginning spring 2020

Securing mental health services within a shifting health and social care landscape

- We support NHS England & NHS Improvement's proposal that the Government should give CCGs and NHS providers shared new duties to promote the 'triple aim' of better health for everyone, better care for all patients, and sustainability, for their local NHS system and for the wider NHS. This should include an explicit requirement to achieve parity of esteem between mental and physical health care.
- The Government should introduce an obligation in primary legislation to reduce inequalities, including amending the statutory duties placed on CCGs, NHS England & NHS Improvement, local authorities and the Secretary of State. This should include:
 - an explicit requirement to assess the gap between people with mental health problems accessing health and care services and the rest of the population
 - a plan to improve and/or integrate services to close this gap year-on-year, and
 - an explicit requirement on the Secretary of State for Health and Social Care to assess how well NHS England & NHS Improvement and Public Health England have fulfilled these legal duties and respond publicly each year.

Advice for local leaders:

Implement national policy commitments

- Mental health and Long Term Plan ambitions to improve mental health to be reflected as a top priority with the full programme delivery supported and tracked at ICS board level. This should align with the national NHS Mental Health Implementation Plan.⁹
- As ICSs and STPs develop their 5-year strategies to reflect the mental health commitments in the *NHS Long Term Plan* and its implementation framework and supplementary guidance, the commissioning, design and implementation of any new models of care should be consistent with the requirement to deliver parity of esteem.

Key theme 2: Planning process - engaging and collaborating

- Mental health needs to be a standalone ICS workstream as well as be embedded throughout other relevant workstreams.
- Local leaders should begin with planning mental health services at 'place', which should translate to ICS level if there is good evidence and reason to do so at scale.

- Leaders need to know how to co-produce and then communicate changes to the public. Patient and carer engagement needs to be meaningful and sustained.
- All plans made in ICSs will succeed or fail depending on the workforce. ICSs present an opportunity for workforce planning and joint training across a wider geography spanning multiple providers, as well as improving clinical leadership.

Recommendations for national bodies:

Ensure transparent and accountable care

- All ICS should have an identifiable lead Mental Health Provider and a regional mental health Senior Responsible Officer (SRO).
- NHS England & NHS Improvement should publish and keep updated an organogram with contact information of each mental health SROs at the regional level, as well as ICS leads, mental health leads and workforce leads, to increase visibility and accountability.
- Building on earlier published details, NHS England & NHS Improvement regional teams should clarify how they will support ICSs to work in collaboration with their partners, and what action they will take if relationships break down.
- By end of 2019, NHS England & NHS Improvement should review each STP/ICS on their mental health plans, level of planned integration, and mental health leadership representation (including people who use services) and support those that need further development. This should form part of a more sophisticated approach to assessing and supporting the performance of STPs and their readiness to progress to an ICS or ICP as directed by a joint national transformation strategy.

Workforce and training for ICSs

- NHS England & NHS Improvement should hold regions and local areas to account for developing and implementing local 'people plans' which fulfil the requirements set out in the NHS Mental Health Implementation Plan, the interim NHS People Plan as well as Stepping Forward to 2020/21: Mental Health Workforce Plan for England.
- NHS England & NHS Improvement and Health Education England should provide greater clarity about the roles and functions of their organisations in national workforce planning and how they will work more strategically and cooperatively with employers and universities.
- By the end of 2019, NHS England & NHS Improvement should clarify the role and governance arrangements of newly formed regional teams for mental health and regional mental health SROs.
- By the end of 2019, NHS England & NHS Improvement and Health Education England should publish the final *NHS Long Term Workforce Plan (People Plan)* including a strategy for the next 10 years that aligns with the mental health commitments in the *NHS Long Term Plan*. This should include mental health workforce numbers required to deliver service expansion, the number of new medical school places required over the period, as well as a transparent process to allocate those places to medical schools that have a strategy in place to help tackle the shortage specialties issue. a strategy for recruitment and retention of the mental health workforce and plans to introduce new roles and ways of working that promote integrated care for people with mental health problems.
- By end of 2019, Health Education England's regional leads should assess the quality of mental health workforce plans at ICS level for 2019/20 and beyond, with feedback made available to the public.

- To bring together commissioning and workforce activity we strongly recommend that the Government revisit whether national responsibilities and duties for workforce functions are sufficiently clear, as proposed by NHS England and NHS Improvement.
- Health Education England should ensure that a substantial proportion of the CPD budget is ring-fenced for mental health, in line with the size of the mental health workforce with an additional sum to reflect past disparity.

Advice for local leaders:

Engage and collaborate

- Engage with patients, public and local Healthwatch to develop a shared understanding of patient needs and work together to design services to meet these needs.
- Engage with the NHS workforce, including psychiatrists, nurses, psychologists, allied health professionals and other mental health professionals to ensure a shared understanding of patient needs and system challenges, and improvements are designed to meet them in a collaborative way.
- Work with local health and social care partners, including local authorities, the voluntary sector and the independent sector considering needs identified through the Joint Strategic Needs Assessments (JSNAs) and the Joint Health and Wellbeing Strategies (JHWSs) to improve public mental health, including addiction services, children and young people's mental health services, supported housing, employment support as well as suicide prevention programmes.

Workforce planning and training

- Develop a credible mental health workforce plan (as part of the local people plan) - including recruitment, training, retention and wellbeing schemes – that will allow to recruit and retain the necessary workforce to meet the mental health priorities of the local population. This should be consistent with the ICS level workforce trajectory to implement the remainder of *Stepping Forward* plus the mental health workforce requirements set out in the NHS Mental Health Implementation Plan.
- Fully understand the current mental health workforce and required expansion numbers, drawing on national guidance and tools consider how this translates into provider-level expansion plans, including key local pressure points for service areas or staff groups, and mechanisms to mitigate these issues.
- Ensure workforce information is accurately recorded in the Electronic Staff Record.
- All frontline staff should receive appropriate training in mental health.
- ICSs should ensure opportunities for joint training for all staff across organisations.

Key theme 3: Population health management, data and outcomes

- ICS leaders should prioritise work with local government and the voluntary sector to help disadvantaged neighbourhoods; population health management and better data allow the system to target areas requiring most attention.
- ICSs provide an opportunity to develop better data and analytics for mental health as part of their work on population health management.

- There is an opportunity for greater alignment between ICSs and the statutory Health and Wellbeing Boards that operate at place level to improve outcomes for the population.
- There is a wealth of information in the system, but this can be overwhelming, and leaders can find it difficult to make the best use of it.
- Leaders need to identify how they can get data and outcomes right at a system level, not just an organisational level. This involves anticipating system-level benefits and being able to measure them effectively.
- Consideration should be given to what a population health orientated approach means for the role of psychiatrists, and other health professionals, including future training requirements.

Recommendations for national bodies:

Support local areas with population health management

- When considering NHS England and NHS Improvement’s proposals for an “NHS Bill” the Department of Health and Social Care and the Ministry of Housing, Communities and Local Governments should evaluate the effectiveness of Health and Wellbeing Boards and review their powers.
- Public Health England should be resourced to further support and strengthen Health and Wellbeing Boards to ensure they can drive local improvements in mental health care.
- By Spring 2020 the Department of Health and Social Care should commission NHS Digital to link mental health services (MHSDS), community services, and acute services (HES) data so that it can be used by ICS leaders to understand the local population health needs more accurately.
- NHS England & NHS Improvement and Public Health England should provide local systems with guidance and examples of good practice that demonstrate how population health management approaches can help address mental health issues as well as wider public health issues.

Advice for local leaders:

Invest in population health management

- Develop a population health management workstream with mental health expertise.
- Develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners’ collective ambition for improving outcomes for local people to monitor performance against the outcomes framework annually.
- Address and measure outcomes that are important to patients and service users, identified through a process of co-design.
- Work towards ensuring everyone in need of support from mental health services has equitable access to effective early interventions and equitable experiences of care and outcomes across all protected characteristics.
- Incentivise and hold providers to account through system-wide outcome and performance measures covering performance, experience, and integration.
- Commissioners should ensure all providers, including third and independent sector providers, submit comprehensive data to the Mental Health Services Dataset (MHSDS) and IAPT dataset.

- Promote a culture which enables clinicians to collect and report patient outcome measures routinely.
- Streamline data collection to reduce clinical burden while also improving clinicians' access to key information and empowering people who use the services to self-monitor.

Key theme 4: High quality care using new contractual models

- Integration of mental health with physical health and community services is likely to be the dominant model but providers are all on different trajectories. ICS leaders can choose to start with how services are delivered, or how services are contracted.
- Provider collaboratives were considered to enable strengthening the mental health providers' position within the local health economy. But there was also an awareness that provider collaboratives are not population health models so do not in themselves incentivise the rest of the system to improve mental health services.
- Contract key performance indicators need to be simplified and reworked around outcomes.
- Alliance models provide an opportunity for shared targets on mental health, which could support other areas of the system to look at mental health.
- Local areas need to consider how best services from within one organisation can be split to get all the positive benefits of integrating with another organisation without impacting negatively on patient care and outcomes (e.g. uncoupling a mental health trust's community mental health services from acute inpatient beds without loss of continuity of care). Joining one element of mental health services with other health services at the expense of fragmenting mental health services is likely to be detrimental.
- There are concerns of asset stripping from mental health trusts by bigger acute trusts involved in mergers or acquisitions.
- Many mental health trusts are too small to have their voice heard effectively in the ICS agenda and might face re-organisation. These trusts are most likely to need to form a partnership with other providers to maintain viability as ICSs develop.

Recommendations for national bodies:

High quality care using new contractual models

- By end of 2019, NHS England & NHS Improvement should require all CCGs using an ICP contract to report their performance on mental health in a way which is comparable to other CCGs without ICP contracts. This will allow sufficient benchmarking across England to ensure the *Five Year Forward View for Mental Health* performance standards are being delivered and ICPs are having a positive impact.
- Further to the proposals for legislative change, the College recommends that the Government should enable NHS trusts acting as lead providers of provider collaboratives to act as statutory NHS bodies to commission specialised services for mental health, where clinically appropriate.
- NHS England & NHS Improvement should assess the benefits and any unintended consequences of ICPs compared with improving joint working through ICSs, including the scope of the draft ICP contract, particularly whether mental health

services should be incorporated, either in a partially integrated or fully-integrated capacity.

- Building on the evaluation strategy for new care model vanguards, NHS England & NHS Improvement should publish an evaluation of the benefits and any unintended consequences of delegating commissioning responsibility to provider collaboratives for mental health programmes, compared with the existing joint working arrangements.
- By autumn 2020, NHS England & NHS Improvement should publish national and local evaluations of New Care Models, including an assessment of their impact on people with mental health problems as well as on mental health and wellbeing-related outcomes across the wider population. This should build on a September 2019 evaluation¹⁰ where patient outcome data was not yet available.
- NHS England & NHS Improvement should review all organisational mergers which include mental health services for the risks and benefits in the short- to medium-term given the paucity of evidence of the associated impact, and in the long-term must require a comprehensive risk/benefit analysis.

Advice for local leaders:

Integrated Care Providers, organisational mergers and acquisitions

- Where mental health services are within scope, ICPs' priorities should align with the commitment to achieve parity of esteem between mental and physical health and national policies to achieve the *Five Year Forward View for Mental Health* and the mental health proposals in the *NHS Long Term Plan*.
- If an NHS lead provider is awarded an ICP contract which results in sub-contracting a mental health trust to provide services within scope, this should be required to happen in a mutually beneficial way with mutual agreement. A CCG should involve mental health trusts throughout this process so that mental health services are not re-procured if seen as detrimental or disruptive to service delivery.
- Consider making the ICP contract scope as wide as possible or put in place sufficient measures to mitigate risks of cost-shunting between providers outside of the ICP. If mental health services are out of scope of an ICP contract and so remain under their standard NHS Contract, local leaders should take steps to prevent cost-shunting as there is a risk that ICPs will be inadvertently incentivised to divert people with mental health problems away from their services, even if this is not clinically or financially appropriate. This will add greater pressure to mental health trusts as well as primary medical services.
- STPs/ICS and ICPs to take responsibility for working together to align plans to streamline commissioning for people within the same population footprint, to improve outcomes and ensure funding is used in the most effective way which may require a flexible delivery approach.
- Primary mental health care should be a core requirement of any primary medical services integration agreement, even if the local mental health trust(s) are not part of the ICP.
- If considering an organisational merger or acquisitions, a full risk/benefit analysis should be conducted for providing cost-effective integrated care and ensure they do not unduly disadvantage mental health services and the people who use them at such a critical time.

Key theme 5: Leadership

- As ICSs develop, there's enthusiasm for mental health trusts to be leaders, not

followers. Mental health leaders' experience of working across complex systems is invaluable in supporting others to adapt.

- Consideration should be given to the current leadership capability in mental health in order to maximise this existing resource and how we can support and develop the leaders of the future.
- More must be done to promote clinical leadership across ICSs, but we cannot just expect leaders to fight for mental health; they need to be supported with cogent arguments to influence the wider system.
- A common language is required to ensure that all staff understand the rationale for ICSs and their role

Recommendations for national bodies:

Empower the leaders of the future

- Regional mental health SROs should be linked into every STP/ ICS programme board in their region.
- By spring 2020, Health Education England should establish a Future Mental Health Leaders programme led by the NHS Leadership Academy, in partnership with professional bodies such as RCPsych, building on the similar 'Future Clinical Commissioning Leaders' programme.
- The Royal College of Psychiatrists should establish a regional engagement programme across England to support its members in working with ICSs in implementing the NHS Long Term Plan.
- By spring 2020, the Royal College of Psychiatrists should work with its members to grow mental health leaders of the future, with a particular focus on gender and ethnic diversity of leadership.

Advice for local leaders:

Leadership

- Mental health leadership should always include people who use services, with appropriate training, development and support. With support from commissioners and other partners, mental health trusts, and other trusts providing mental health services across England should involve people who use services, including those from Black, Asian and minority ethnic groups, in all aspects of their organisation, such as service co-production, planning and delivery of care.
- Clinicians should be supported to engage with ICS developments, particularly where the service encompasses a special group such as older people, children and young people, or those requiring specialised health services.
- Every clinical interaction should be seen as an opportunity to promote mental and physical wellbeing and NHS staff should build relationships and networks to enable them to do this together.

Key theme 6: Governance

- ICSs are not statutory bodies, so they rely on the willingness of local leaders to participate.
- There are challenges associated with setting up joint committees between commissioners and providers and maintaining the integrity of existing governance

arrangements. Learning about how these are overcome needs to be gathered and shared.

- ICSs provide an opportunity to collectively manage performance across the system, but trusts are still individually held to account by NHS England and NHS Improvement.
- Governance arrangements need to be agreed with all parties and made simpler and more transparent.

Recommendations for national bodies:

Changes to NHS structure and governance

- We note that proposals to allow the Secretary of State to set up new NHS trusts to deliver integrated care across a given area will not be progressed. However, appropriate safeguards must be put in place in circumstances where mental health services are within scope (as discussed in earlier recommendations relating to integrated care providers, organisational mergers and acquisitions).
- While proposals for NHS Improvement to have targeted powers to direct mergers or acquisitions involving NHS foundation trusts will not be progressed, it remains critical that appropriate safeguards are put in place in circumstances in cases where mental health trusts are involved.
- We support NHS England's view that trusts and CCGs should be able to form joint committees in every ICS to exercise functions, and make decisions, jointly. Statutory guidance relating to this should include an explicit requirement to include mental health leaders at an executive level.
- We support NHS England's view that they should be given the ability to allow groups of CCGs to collaborate to arrange services for their combined populations. CCGs should be able to carry out delegated functions, as if they were their own, to avoid the issue of 'double delegation', and groups of CCGs should be able to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions. This must include an explicit requirement that each CCG within the collaboration meets the Mental Health Investment Standard individually, as well as collectively.
- We support NHS England's view that they should be enabled to enter into formal joint commissioning arrangements with CCGs including providing the ability to pool budgets. This should include a commitment to report spending and activity for mental health in a transparent way.

Advice for local leaders:

Governance

- Senior mental health leaders should be at the heart of all relevant local decision-making structures.
- Ensure at least one senior mental health leader in the programme management team is responsible for overseeing the implementation for each new model of care and involved in any relevant contract negotiations for ICPs. Also engage or at least have input from specialists where the service encompasses a special group such as older people, children and young people, or those requiring specialised health services.

Key theme 7: Funding, whole population budgets and incentives

- ICSs should be able to determine the payment approach that matches the current issues of the system.
- Whole population budgets provide useful flexibility for providers to work together towards outcomes rather than activity, but there is concern about the risk borne by mental health providers because of historic underinvestment and a paucity of activity and outcome data.
- CQUIN and QOF should incorporate broader mental health metrics to ensure quality and outcomes for mental health improvement continue to be incentivised across the system. But there is uncertainty about how an ICS would be able to release cash at scale.
- The enhanced Mental Health Investment Standard is seen as useful, but concerns remain that funding for mental health could be diverted. Mental health trusts' leaders will look to ICS Leads to join them in holding CCGs to account should the mental health investment not be sufficient.
- The new funding only sustains the NHS. Two major gaps remain: public health and social care. The financial position of local authorities is significant to the success or failure of system-wide transformation. Addressing this is vital to ensuring ICS can support strong collaboration between health and social care with partners in local government and the voluntary sector on prevention and recovery.
- A longer-term ICP contract duration can offer stability to incentivise providers to invest in new care models; however, this needs to take account of the challenges for mental health, including risks of a capitated payment approach and the limited data available to support outcome-based payments.

Recommendations for national bodies:

Protect funding in mental health

- The Department for Health and Social Care and NHS England & NHS Improvement should fairly apportion any additional capital funding to mental health trusts based on ICS estates and capital plans.

Advice for local leaders:

Funding, whole population budgets and incentives

- Jointly agree a mental health investment strategy, taking account of the NHS Operational Planning and Contracting Guidance 2019/20, *NHS Long Term Plan* implementation framework and supplementary guidance, signed off by the ICS board, and in place across partners in the ICS, including:
 - plans for the use of additional baseline mental health funding commissioning services that deliver improved services set out in the NHS Long Term Plan
 - Delivering of the Mental Health Investment Standard to ensure it covers all priority areas for the programme and related workforce requirements
 - quality assurance of mental health delivery, including evaluating the value and return on investment of mental health programmes to facilitate forward planning,

<ul style="list-style-type: none"> ○ agreement across the health system that efficiencies delivered through mental health initiatives will be reinvested back into mental health services to promote sustainability.
<ul style="list-style-type: none"> • Fairly apportion additional capital funding to mental health trusts based on ICS estates and capital plans.
<ul style="list-style-type: none"> • For whole population budgets, the capitation population needs to be defined carefully and in detail and must be linked to the existing funding formula method to ensure that patients with mental illness are not disadvantaged. Deprivation must be adequately adjusted for within budgets and should be if existing formula rules are applied. Attributing outcomes (i.e. a share of a capitation payment) to one of several providers in a fragmented market or pathway will be extremely difficult in mental health.
<ul style="list-style-type: none"> • When outcomes are linked to payment, as in an alliance contract or an ICP contract, careful consideration should be given to fair payment as many of these factors may be out of the sphere of influence of local providers and commissioners, especially social care provision.
<ul style="list-style-type: none"> • In ICP contracts, include long-term proxy outcomes measures on public mental health and prevention, so that improvements are tracked when contracts span years/decades. This must be balanced with local services, access and waiting time standards and delivering outcomes for those who use services and these outcome measures operate within a different time scale.
<ul style="list-style-type: none"> • CQUIN and QOF should incorporate broader mental health metrics to ensure quality and outcomes for mental health improvement continue to be incentivised across the system.

Emerging lessons and next steps

We heard that ICSs have the potential to improve patient experience, reduce morbidity and mortality rates, reduce the unmet need in mental health and innovate to go further faster. Through system-wide collaboration, there is a real opportunity to improve and join up mental health services with the rest of the health and care system and there is a strong sense that mental health trusts should be leaders, not followers, as their expertise in moving care from hospital settings into the community and working across complex health and care systems is invaluable. ICSs also provide an opportunity for system-wide incentives to improve mental health care, linked to outcome-based payments, either through alliance or ICP models.

But major challenges remain. Predominantly, this revolves around the viability of mental health trusts, many of which might be too small to have their voice heard and could face re-organisation. In addition, there is a need to consider the current leadership capability within the mental health sector and how we can support and develop the leaders of the future. The pace and scale of change are also a considerable challenge and local leaders should be cautious when thinking about complex organisational change.

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