Mental Health Network
NHS Confederation

Centre for Mental Health

Mental Health Economics Collaborative

Now or never

A systemic investment review of mental health care in England

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Contents

Acknowledgments

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Executive summary

This report responds to the challenge facing policy makers – how to enhance, treat and improve the nation's mental health. As with any system, there are challenges and areas for improvement. Money is not the only answer. How and where it is spent also counts.

Rather than make a list of demands for cash, this report perceives the NHS in existential terms, firstly placing it within a historical context to demonstrate how many of the challenges posed today were faced two centuries ago. Subsequent legislation has modified rather than reinvented services, with the focus remaining on acute need, public protection and, ultimately, segregation of health care into two systems: one for the body, one for the mind.

We are where we are. Each short chapter identifies a systemic problem, substantiates it and describes a solution with cost savings. Ideas are presented on the understanding that each service is part of a whole – spending in one place means divestment elsewhere. The trade-offs in terms of costs versus benefits are calculated through that lens.

Our analysis finds:

There is an opportunity for Integrated Care Systems to create a simpler investment mechanism where areas can plan for population health in a new and logical way. To do this, they must integrate mental health care alongside physical health care, consistently and with parity.

The return on investment is highest for interventions which improve and enhance mental health. Yet this is the area where least money is currently spent. Programmes offering alternatives to acute care have demonstrated vast savings. There are significant opportunities to fund greater preventive health care by reducing spend on supplementary acute care, such as delayed discharges.

Waiting lists are a signal of systemic failure as demand is greater than supply. No illness is improved by delaying treatment. Whilst resources have to be rationed, waiting lists lead to worsening mental illness and greater costs.

Digital technology is one way to enable the NHS to meet rising demand for mental health care. Evidence shows that digital delivery is not suitable for all. It expands choice rather than replacing in-person treatments. But it must be accompanied by practical freedoms for staff, such as being able to work for multiple NHS trusts at one time.

Staff are the NHS's biggest asset. Exhausted by the pandemic, there is a need for a well-resourced strategy for mental health which commits to providing the equivalent cost of a 1% increase in absenteeism for clinical treatment to help them to recover.

Treating physical and mental health care simultaneously has been recommended for many years and is shown to improve patient outcomes whilst reducing treatment costs. The life expectancy of someone with severe mental illness is at least 15 years shorter than average. Clearly, the current 'one patient, two systems' approach does not work.

Information governance presents a golden opportunity to understand how patients use health care and would be an efficient alternative to paper-based records. Being able to identify groups of patients with high treatment costs and poor outcomes would enable alternatives to be offered. However, there are also risks with how that data is used, stored and sold.

What gets measured, gets managed. The absence of an outcomes framework across the mental health care system means government cannot measure value for money, return on investment or compare different treatments. Many such frameworks have been designed and suggested but none has been adopted at scale. This report recommends that life expectancy be the primary vector of success.

Finally, the perennial of interagency working. Whilst always dependent on local conditions, characters and willpower, removing restrictions that have stopped collaborative investment and risk-sharing would unlock financial rewards.

The greatest innovation often emerges at the most challenging of times. The NHS was created in the immediate aftermath of World War II. Covid-19 presents many challenges, but also the opportunity to resolve long-term problems with fresh solutions that save money and have the potential to improve all our lives.

Chapter	Issue	Facts and figures	Resolution
1	The tenets of mental health care are largely unchanged since 1845.	The NHS was created in 1948, but the first Mental Health Act was not passed until 1959.	Legislation will be transformative when it challenges those accepted norms, including the mental health estate, focus on acuity and lawful detention.
2	The NHS is structurally complex, making it difficult to measure and achieve consistency and value for money.	Despite the system's complexity, the number of managers in mental health services has fallen by 23% since 2010.	Integrated Care Systems are an opportunity for improvement but must be required to work with the wider community and its leaders.
3	Government invests far more in mental illness than in mental health.	Less than 3% of NHS mental health budgets are spent on enhancement or preventive care.	Invest more in enhancing and preventive services which have a high return on investment.
4	Waiting lists lead to worse patient outcomes and increased use of emergency services.	Almost one in five people wait more than 3 months between their first and second IAPT appointment.	Measure outcomes and waiting times. Invest in reducing delays for treatment.
5	Demand for mental health care is rising, and both current and projected staff numbers are insufficient.	Demand for mental health care is forecast to increase up to three-fold over the next five years.	Invest in staff productivity, including flexible working and technology for digital delivery of care.
6	NHS staff face burnout, stress and mental illness as a result of the pandemic.	A 1% increase in NHS staff absences would cost £476,000,000 per year.	A coherent investment strategy is needed to enable staff to recover from the psychological effects of the pandemic and commit at least 1% of absenteeism costs to doing so.
7	Mental and physical illness are treated via two separate systems.	The life expectancy of someone with severe mental illness is 15-20 years shorter than average.	Treat mental and physical health problems simultaneously because they are synonymous.
8	The NHS has limited capability to understand patient data because it is recorded and stored inconsistently.	The NHS Care Records Service was established in 2005, but abandoned in 2013.	Proceeding with caution, a national database would improve patient treatment but must be protected from sale or exploitation by third parties.
9	Outcome measurement is poor and lacking in the NHS.	£13.3bn is spent on mental health care for which there is no measurement of outcome or value for money.	Understanding the return on investment is crucial to understanding if money has been well spent.
10	Interagency working is hampered by the number of public organisations and a lack of consistent framework to share outcomes and investment.	There are 398 councils, 533 constituencies, 43 police forces and 15 government departments in England.	An agreed code for public bodies to easily and rapidly pool budgets, outcomes and responsibilities would help them to achieve common goals and unlock financial savings.

Introduction

It has been an adverse year. The Covid-19 pandemic has been extremely challenging, bringing death, lockdown, isolation and uncertainty. The NHS will need two to three times its current capacity to adequately meet and treat the expected increase in mental health problems.

With the Comprehensive Spending Review due this autumn, ideas for how to meet this challenge will be needed. Pumping ever-larger amounts of cash into the existing system is not, in itself, a solution. Stubborn problems such as widespread staff vacancies, disjointed patient care, lack of outcomes measurement and an over-reliance on acute care require attention if money is to be invested wisely.

This briefing concisely describes ten policy problems and offers solutions with cost saving calculations for consideration by those planning future health spending. Although today's Covid-generated problems are new, the weaknesses in current systems are historic.

Rethinking long-held beliefs and accepted truths about treatment for people with mental health difficulties is needed. This report offers a framework to do this.

Descriptions of each policy area are deliberately short. Further information on any or all chapters is available from Centre for Mental Health.

1. The historical context and current policy

Our history

The 1845 Lunacy/Lunatics Act and the County Asylums Act were the first major set of English mental health laws. They formalised the 1808 County Asylums Act and 1774 Madhouses Act which had attempted the regulation of private asylums that had rapidly appeared during the 19th century but had not resulted in a recognisable mental health system.

This Lunacy Act created the tectonic plates of English mental health care and principal tenets that have endured 170 years. These are:

1. Lawful incarceration and exile from society (asylums) are appropriate mental health treatment
2. The view that without asylums people with mental illness will be in prison or workhouses
3. The state as provider and regulator of mental health care
4. Vagueness about whether hospitals can treat and detain against a person's wishes
5. The role of local authorities as financiers of services
6. Detention is reviewed by commissioners, not challenged by directly by patients
7. A regime of treatment inspections – in this case by the Home Office – and registration with the Commission
8. Loose or no definitions of mental illness.

Subsequent legislation

New laws and reform have been infrequent. Eighty-five years after the Lunacy Act, the Mental Treatment Act 1930 was the next legislative milestone. People with mental illness became 'patients' not 'lunatics', and institutions for their care became 'mental hospitals', not 'asylums'. In practical terms, not much changed. It encouraged local authorities to provide outpatient services and aftercare, but as new services weren't mandated, provision was highly variable across local areas.

Eleven years after the creation of the NHS in 1948, the Government legislated for how it might offer mental health care too. The Mental Health Act (1959) built on the Percy Commission (1957). It removed the distinction between psychiatric and other hospitals, encouraged greater equality between mental and physical health services, and required local authorities to provide residential care, training, and other support services for people living with mental illness in the community (Wright, 1997). In practical terms, not much changed. The opportunity to integrate mental health within the rest of the NHS had been missed.

The Mental Health Act (1983) introduced new measures mostly concerning compulsory admission. New clauses included the introduction of second opinion doctors for compulsory treatments and the requirement for local authorities to employ appropriately qualified mental health social workers. The Act was further amended in 2007. New proposals were highly contested and ultimately not much changed. Reforms were proposed partly in response to concerns from some parties about public safety: mental illness was once again portrayed as a public nuisance.

The Community Care Act (1990) introduced a requirement for local authorities to help vulnerable people remain in the community. Although building on sentiments from the 1957 Water Tower speech, which made the case for care in the community, the move was controversial because of high-profile media coverage of homicides by people under this provision which increased stigma and fear.

In the period since, governments have published a number of national mental health strategies for England. The National Service Framework for adult mental health services in 1999 was the first and most ambitious,

leading to the development of a wider range of community-based services (supported by significant increases in funding) in the 2000s. The last decade saw an increasing frequency of successive strategies, including *No Health Without Mental Health* in 2011, the *Five Year Forward View for Mental Health* in 2016 and parts of the *NHS Long Term Plan* in 2019.

The Health and Social Care Act 2012 introduced the widest range of health reforms since the creation of the NHS in 1948. Importantly for mental health, it enshrined 'parity of esteem' in law for the first time, establishing the principle by which mental health must be given equal priority to physical health. Measures of success are unknown.

Current legislation

The provisions of the 1983 Mental Health Act and 2007 amendments are still in place today, but 2021 could be a landmark year for mental health. Proposals have been brought forward to modernise the Mental Health Act and integrate health and care services. Reform of the wider health system through the Health and Care Bill will close the separation between NHS commissioners and NHS trusts, and compel the NHS to work together and with other local partners, including local authorities and the voluntary sector, as Integrated Care Systems (ICSs). ICSs could provide an opportunity to reimagine health systems to be less focused on buildings and more on community mental health and social care needs. The Mental Health Act, meanwhile, is set to be updated using the blueprint envisaged in the 2018 Independent Review, led by Sir Simon Wessely. Patient rights will be given greater weight versus risk. Autism will no longer be a detention diagnosis (a move not recommended in the Independent Review but included in the Government's subsequent white paper). Breakthroughs, but ones which require significant planning and investment.

For any legislation to be truly transformational, there are three enduring legacies requiring reform:

1. The estate. Bricks and mortar are perhaps the most visible sign of our mental health care history. 18% of the NHS estate predates the creation of the NHS (Naylor, 2017). The Independent Review of the Mental Health Act warned that the mental health estate is among the worst the NHS has to offer. Dormitory accommodation and mixed sex wards are yet to be eradicated.
2. The mental health system has evolved to address the needs of the relatively few people with the highest acuity and complexity. In public health, for example, which is currently funded by local authorities, only around 1-2% of spending targets mental health improvement.
3. The principle of lawful detention. From the mid-nineteenth century to the present day, there has been a consistent belief and acceptance that it can be appropriate to deprive people with severe mental illness of their liberty to keep them and others from injury and harm. The impact of detention on individuals' health and care needs has historically been a secondary concern. The proposed Mental Health Act reforms commit to a new focus on 'therapeutic benefit' for detention and treatment across new legislation, but require new safeguards around rights and patient choice to make this real.

Conclusion

The core tenets of mental health care remain largely unchanged since 1845 and subsequent legislation has focused on language and acuity. Laws are important because they determine our perception of people who are mentally ill, their human worth and how they should be treated. Ultimately, they have legitimised the acceptance that mental health care is, and always has been, inadequate. The alternatives of prison and workhouses are worse.

2. The impact of NHS structural complexity on investment realisation

Systemic issue

- The NHS is not a single organisation, but a complex framework of 1,311 different bodies which have competing and complementary budgets, priorities, power and outcomes
- Health care investment is decided centrally but how that money is spent is determined locally by many different organisations
- Outcomes are dependent on hundreds of organisations collaborating successfully, diffusing lines of accountability
- This makes it difficult to measure and achieve value for money
- Integrated Care Systems (ICSs) offer a policy solution but require outcome standardisation and clear accountability frameworks.

Argument and substantiation

'Our' NHS is amazing, seeing 1 million patients every 36 hours (Royal College of General Practitioners, 2021). It is publicly perceived as one organisation under a happy rainbow badge. It conveys an idea of simplicity. Care from cradle to grave. The same provider of care whether in Lewisham or Leeds. The NHS is the biggest employer in Europe and the world's largest employer of highly skilled professionals (NHS UK, 2019).

The reality is very different and more complex. There are 1,311 'companies' (NHS Confederation, 2021) within the NHS as we know it, plus a further 7,454 GP practices:

- 207 clinical commissioning groups
- 135 acute non-specialist trusts
- 17 acute specialist trusts
- 54 mental health trusts
- 35 community providers
- 10 ambulance trusts
- 785 for-profit and not-for-profit independent sector organisations (included because these are perceived as NHS services from the perspective of the patient).

Each group, trust or system has its own structures, identities, priorities and aims. They can be competitive. They can be rivals. They can be profit-making.

The increasing number of organisations has not led to an explosion of management costs. In mental health trusts management is lean, down 23% since September 2010 to 955 managers and senior managers: 0.8% of the mental health workforce (NHS Digital, 2021a) (in comparison to 2.5% across the NHS).

Claims of more managers than beds are wrong and NHS management costs are comparatively low. The OECD found that the average spend on administration by member states is 3% (OECD, 2017). It also concluded that wide disparities in management spending had "no obvious correlation with health system performance".

However, systemic complexity means there are hundreds of pathways from a national policy to local delivery. The diffusion of accountability and lack of a standard outcomes framework leads to inconsistent provision of services and care.

The resulting system failure

Public perception is that the NHS is one organisation and therefore pulling an investment lever in Whitehall will result in consistent, measurable outcomes across the nation. Instead, funding is diffused between a complex network of organisations.

This makes it difficult for government to translate a policy announcement into consistent delivery of improved mental health care.

Proposed solution

Integrated Care Systems – currently being formed across the country – could minimise this by creating one overarching 'place-based' organisation.

They could create a simple network of organisations who receive investment from government which they spend in order to achieve agreed outcomes.

Argument and substantiation

Integrated Care Systems bring together the NHS organisations and local authorities in a geographical area of about a million people each in order to plan health and care services. Every area in England is now part of one of about 50 Integrated Care Systems.

At present, Integrated Care Systems are not organisations themselves but collections of bodies that have come together to share responsibility for organising health services in their areas. They include clinical commissioning groups (which are currently responsible for spending NHS funds locally) and the major providers of acute (hospital), community and mental health services. They also include county and unitary local councils that are responsible for public health and social care services.

The aim of Integrated Care Systems is to foster more collaboration between different parts of the NHS and with social care services. The objective is to get all parts of the system to agree common goals and to work together to achieve them. This includes improving the overall health of the population as well as making health services work better together – such as closing the gaps between mental and physical health care. Collaboration between NHS bodies will reduce costs of competitive tendering.

ICSs are responsible for implementing key aspects of the NHS Long Term Plan, including planned improvements to mental health services. They will receive additional funding to help to improve primary and community mental health services, crisis care, psychological therapies, and children and young people's mental health services.

The Government has introduced legislation to make Integrated Care Systems statutory bodies. They will replace clinical commissioning groups and have ultimate responsibility for how NHS funds are spent in their areas. As part of this change, NHS trusts will also be required to form 'provider collaboratives'. These will be alliances between NHS organisations to foster closer cooperation. For mental health trusts, this might mean joining a collaborative with neighbouring mental health trusts or linking up with their local acute and community trusts.

Integrated Care Systems and provider collaboratives have the potential to create significant improvements to mental health services. By fostering integration and collaboration across the NHS, they could help to close the gaps between mental and physical health care, or between health and social services. They could also improve mental health support, especially for groups of people who are poorly served by the current system. And if they had a focus on prevention, they could help to shift resources to earlier help for people's mental health. There is a specific opportunity to build on the successes achieved during the pandemic, such as integrated care for care home residents.

But they also present some risks and concerns. By creating larger organisations across larger areas, they risk removing decision-making from localities, reducing the connection to communities. They could also marginalise local councils in some areas, further tipping the balance of power towards the NHS and away from public health and social care. There is no guarantee that Integrated Care Systems will put mental health care on a par with physical health – the evidence so far is mixed from the early adopters of this approach.

Conclusion

ICSs are to be welcomed and should be augmented by:

- A standard outcomes framework so that the success of investment can be measured
- Parity of care for mental and physical health
- The requirement to work with the wider community and its leaders – particularly social care, VCS and housing providers – to create provision that responds to patient health needs in the widest sense
- Accountability, ensuring that ICSs are accountable for their priorities, spending, demonstrable achievements and where there are continuing gaps in provision. This must include a specific responsibility for reducing inequalities in access to mental health support as well as experiences and outcomes (Commission for Equality in Mental Health, 2020).

3. Investing in mental health as well as mental illness

Systemic issue

- The return on investment (ROI) is three times higher for preventive care than specialist treatment. Prevention is more cost-effective than cure
- However, less than 3% of NHS investment is in preventive or health-enhancing interventions
- Government is not investing where it will get the greatest return. It invests at the wrong end of the system – illness instead of health.

Argument and substantiation

Current mental health provision can be categorised into five areas:

- Enhancement of health
- Prevention of illness
- Management of illness
- Crisis/acute care
- Prevention of relapse.

The precise spending on each category of care is difficult to calculate because commercial sensitivity means trusts and CCGs do not specify their investment. The Mental Health Investment Standard contains some of this information, but all that is published is a Statement of Compliance, not a Statement of Expenditure. The corresponding dashboard offers limited data.

NHS England spending on mental health care was £13.3bn in 2019/20 (NHS England, 2021), which includes:

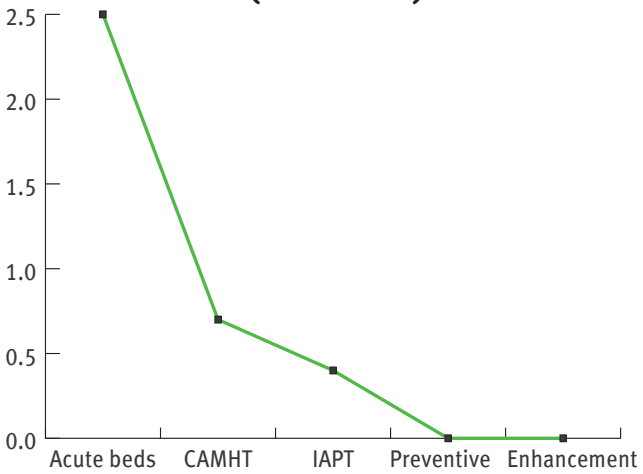
- NHS acute mental health beds: £2.49bn (Curtis & Burns, 2020)
- Community adult mental health services: 748m (NHS Improvement, 2019)
- Psychological therapies (IAPT): £430m.

NHS spending is inverse to return on investment rates. Where spending is low, ROI is high.

The resulting system failure

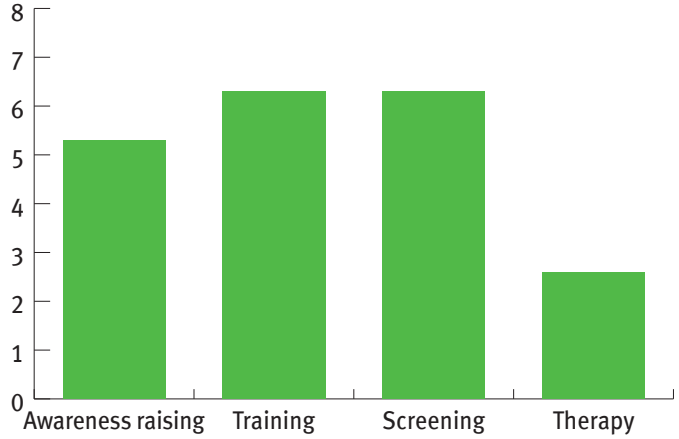
Investment is focused almost entirely on mental illness not mental health, even though prevention is more cost-effective than cure.

NHS Mental Health Expenditure (in £billions)



Source: NHS England and NHS Improvement, 2021

Return on investment per £1 spent (in £)



Source: Hampson and Jacob, 2020

Proposed solution

NHS England should formally categorise spending into the five areas of mental health provision and increase spending on enhancement and prevention.

New investment should prioritise interventions which offer the greatest return.

Given the disparate availability of ROI evidence, immediate work is needed to establish measures for acute services.

Argument and substantiation

Mental Health and Employers: Refreshing the case for investment (Hampson & Jacob, 2020) completed a comprehensive review of 125 reports and investment cases for different programmes funded by employers.

It concluded:

"Our analysis of the stage of the intervention found that on average, awareness raising can provide an ROI of £6 for every £1 invested. Proactive training provides a similarly high average ROI of £5 for every £1 invested. [...] Reactive support, such as offering employees therapy or treatment once their mental health had worsened [...] provided on average, a return of only £3 for every £1 invested."

It should be noted that ROI measures have different time horizons and that when those rewards are received differs based on the treatment offered and the patient group.

The greatest return on investment came from programmes which screened individuals to identify risk factors and provide targeted, early-stage support to preserve their mental health. These programmes were offered universally or to small groups with ROIs of over 10:1.

It is not possible to compare the ROIs described with those for acute care as there is no standardised outcomes framework, limited financial data is published, and no value-for-money assessment is made. In short, investment of £2.5bn of spending on acute beds has no demonstrable outcomes.

There are existing examples of where the NHS has demonstrated how moving resources 'up-stream' away from acute care has achieved significant reductions in expenditure. *Bringing Care Back Home: Evaluating New Care Models for children and young people's mental health* (O'Shea, 2020) quantified that offering community treatment and intensive support instead of acute beds reduced the cost of treatment by £15.3m for a group of just 217 patients – many of whom had been in wards long distances away from home and family.

By investing in community services, there were large reductions in out of area bed days and length of stay in acute beds. There was a correlation between the percentage of budgets invested in alternatives to acute care and the reduction in overall expenditure. In other words, the larger the investment in community provision, the greater the reduction in acute expenditure observed.

Further significant cost reductions could be realised by expanding this approach and others like it.

Costs and benefits

Expansion of the New Care Models approach for young people across all 54 mental health trusts could generate a reduction of £137m in acute care beds whilst improving community care.

Further, comparable savings would be possible for adults who are in acute beds, although it has not been possible to locate the figures for excess mental health bed days in order to quantify this amount.

There is significant scope for reducing spending on mental health acute beds. This could then be invested in community and preventive services where the return on investment is 6:1.

For example, an early-stage support programme costing £200 per person could be offered to 1 million people for £200m which could generate net benefits of £1bn.

Similarly, apps which enhance and maintain mental wellbeing are popular, cost-effective and can be used to help screen when people need additional support.

What discernible difference would this achieve?

Effective, preventive treatment could be offered to a million people, paid for by savings from reducing use of acute care and in particular, the cost of delayed discharges.

Conclusion

The research and spending do not correlate. Government can draw lessons from employers who have focused their mental health care investment to generate the maximum return. Whilst the provision of acute beds, crisis care and specialist services are vital and legal rights, there is a clear financial case for significant investment in enhancement and prevention.

A crucial lesson from the New Care Models was the need to invest in alternatives before reducing the acute care available. Whilst costly in the short-term, it unlocked larger long-term savings.

4. Waiting lists

Systemic issue

- Waiting lists are a means of constraining demand
- The financial model presumes that waiting creates some demand displacement (patients seek help from another source) and some demand evaporation (patients cure themselves). This leaves a smaller group needing care but whose needs have worsened whilst on the list
- The cost of providing acute care to those who worsen is greater than the cost of providing enhancement/preventive care to everyone at an earlier point
- This leads to worse outcomes for patients and causes overspending on acute and emergency care.

Argument and substantiation

Waiting time data are not routinely published outside of Improving Access to Psychological Therapies (IAPT), Early Intervention in Psychosis (EIP), and children and young people's eating disorder services. Therefore, it is difficult to quantify the issue with any certainty. This is unlike any other aspect of NHS provision where times are recorded routinely and used to drive performance.

Evidence suggests a variable picture for more specialised help that extends to long waiting times – even before the pandemic. The Children's Commissioner has also noted wide ranges in waiting times between areas for children. In 2018/19, the average waiting time was over 90 days in 13 CCGs, while the best performing 14 areas saw children in 29 days or fewer (Children's Commissioner, 2020).

The result is that health may deteriorate during the waiting time. The Royal College of Psychiatrists' survey of 513 people with a diagnosed mental illness reported that two-fifths utilised emergency or crisis services whilst waiting for treatment, and one in nine resorted to visiting A&E. 39% reported that waiting has led to a further deterioration in their mental health, which subsequently affected other areas of their life including relationship problems, financial issues, and problems at work (Royal College of Psychiatrists, 2020).

Reichert and Jacob's study (2018) of people using EIP services found "longer waiting time is significantly associated with a deterioration in patient outcomes 12 months after acceptance for treatment for patients that are still in EIP care. Effects are strongest for waiting times longer than 3 months, and effect sizes are small to moderate." It recommended that policies target excessively long waiting lists to improve patient outcomes.

Conversely, scheduled waiting for psychotherapy in patients with major depression did not appear to lead to significant difference in global distress scores from referral to assessment – even with an average wait time of almost 45 weeks (Ahola *et al.*, 2017). However, nearly all (95.7%) remained clinically depressed.

Waiting did not lead to an improvement in health.

The resulting system failure

Waiting for treatment does not aid recovery, it causes increased use of emergency services and results in poorer patient outcomes. Protective factors, such as jobs, are also risked in the absence of treatment.

However, the link between patient outcomes and waiting times for treatment is unproven because data is not routinely or consistently collected; particularly, data on compensatory use of emergency services.

This means that government may be less willing to invest in accelerating access to treatment as the impact is unclear.

Proposed solution

IAPT has demonstrated that waiting list data is useful in demonstrating efficiency, which in turn has helped increase investment. Linking patient outcomes to waiting times – both of which are collected – would provide a critical insight into the link between the two across all mental health services.

Argument and substantiation

IAPT offers some crisp statistics on delivery of care (Thandi *et al.*, 2020):

- In 2019/20 the number of IAPT referrals was 1.69m with 1.1m people starting treatment (Note: contact types include assessments such that starting treatment may be conflated with receiving an assessment session).
- 606,000 people completed a course of treatment (38.8% of all referrals), and 51.1% of those moved to recovery.

Ultimately, this means 28% of those starting a course of IAPT achieve 'recovery'. This enables a policymaker to understand the cost of further investment, the likely result and to ascribe a health care saving to it; a classic 'return on investment' case.

A key determinant of recovery rates is number of sessions. Those who recover, on average, have more sessions:

- Reliable recovery = 7.8 sessions
- Deterioration = 6 sessions.

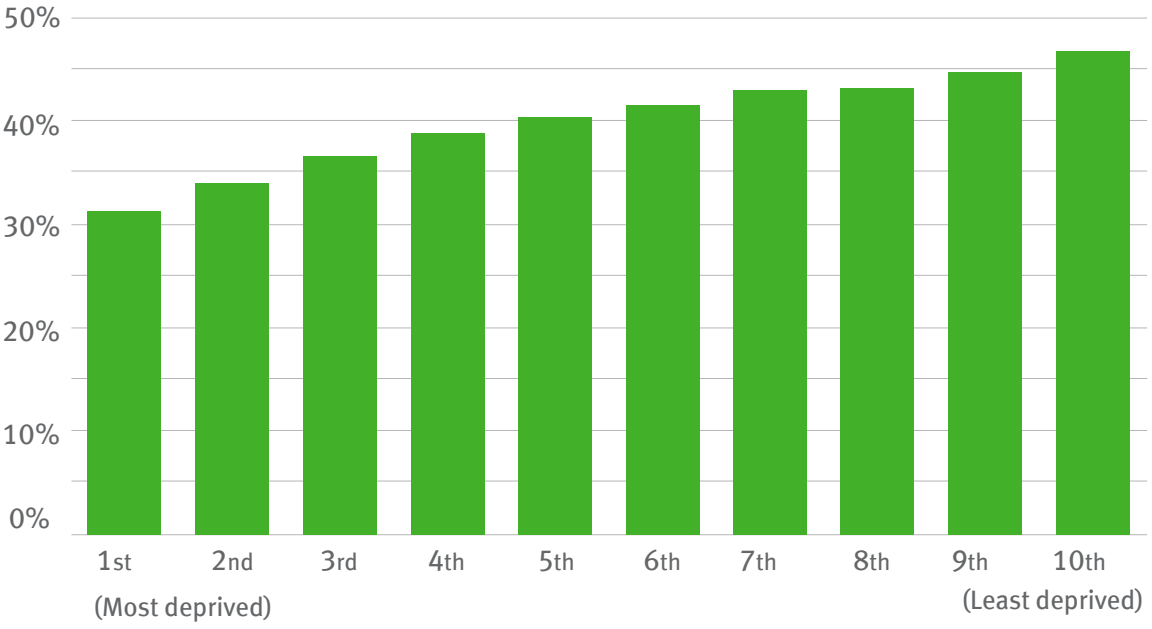
Another determinant is the deprivation of a person's local community. The poorer it is, the less likely they are to receive treatment (Hodgson, 2019 – see chart below), and in turn, recover.

What is unknown, however, is how waiting times impact on recovery, and this is important because there are large variations in accessing therapy. In 2019/20, 87.4% of people started treatment within 6 weeks, but:

- 54.7% waited longer than four weeks for their second appointment
- 33% waited more than six weeks
- 19.3% waited more than three months.

Given the link between health outcomes and timeliness of treatment, understanding how this impacts on IAPT's recovery statistics would be an extremely helpful measure that is currently unpublished.

Percentage of IAPT referrals who receive treatment, by deprivation decile



Adapted from The Health Foundation (2020)

Source: NHS Digital , 2020

What discernible difference would this achieve?

Data has helped capture the benefits and outcomes of IAPT. To drive its continuing improvement, linking recovery data to waiting times would determine if 'rapid' access to psychological therapies is as important as 'improved' access has been.

Applying similar data collection to other mental health services would also establish how waiting times impact on health outcomes. If less waiting leads to better outcomes, future investment could be highly effective if spent on increasing speed of access to existing services.

It is worth understanding if shorter waiting lists:

- Result in improved recovery rates
- Sustain recovery
- Reduce use of emergency and secondary services.

Conclusion

Reducing waiting times for mental health treatment is likely to be a prudent investment. Linking waiting list data to outcomes is straightforward and would illuminate investment decisions by showing how existing services can achieve more when patients have faster access.

5. Investment in productivity – staff deployment and digital technology

Systemic issue

- Staff numbers remain static (2011 compared to 2021)
- The pandemic is forecast to increase demand for mental health services by two to three times the current levels of provision
- New methods of service delivery that raise staff productivity are required to bridge the gap.

Argument and substantiation

The mental health care workforce is a similar size as it was ten years ago, despite commitments in Forward Views, workforce action plans and implementation frameworks.

The NHS mental health workforce consisted of 118,485 people in September 2010, and 122,613 ten years later. Numbers actually fell during much of the decade, with the workforce reaching a low of 108,924 in 2017.

The British Medical Association (2020) concluded that the goal of increasing mental health staffing in the current Mental Health Implementation Plan are not on track to be met. Conceived pre-pandemic, the plan promised increases of 600 psychiatrists, 4,000 nurses, 8,000 psychologists, psychotherapists and psychological professionals, 5,000 support workers and 600 social workers. Increased staff numbers have not materialised yet.

Simultaneously, demand within mental health services is rising. Since 2016 demand has been relatively stable (NHS Digital, 2021b), but forecasting by Centre for Mental Health estimates that the equivalent of 8.5 million adults and 1.5 million children will need access to mental health services over the next five years. This is between two and three times the current levels of provision (O'Shea, 2021).

Increasing staff numbers has proved stubbornly difficult. With demand rising in the short term, there are limited options to quickly increase the numbers of newly qualified people.

The resulting system failure

Supply of treatment will fall further behind patient demand.

Proposed solution

Increased delivery of mental health services using digital technology to:

- Respond to staff and patient demand for flexible working and treatment hours
- Increase existing staff productivity.

Argument and substantiation

The Covid-19 pandemic transformed and increased use of digital technology. Arguably, 2020 was the year in which the NHS caught up with other health providers who had already been using digital tools routinely.

A robust and insightful report by Jackson and Saeidi for Leeds and York NHS Partnership NHS Foundation Trust (Jackson & Saeidi, 2020) captures many of the early lessons drawn from the impact of the pandemic, indicating that there are financial and productivity gains to be derived from digital technology.

The study's findings:

- Travel: "Across the organisation, the average pre-Covid monthly spend on travel and subsistence was just over £60k, this fell to an average of £20k during June, July and August"
- Room hire: The average monthly spend on room hire was reduced from £21,249 between April to August 2019 to £2,261 for the same period in 2020
- The Did Not Attend rate reduced from 15% to 5% between April and July 2020 in comparison to the same period in 2019, although there may be several factors contributing to this; for example, the trust had 40% fewer contacts during this period.
- Digital tools proved flexible and responsive. The velocity at which this service transformation took place with the wholesale shift of treatment online (for a fixed duration) has shown that NHS twenty-year plans can be implemented in twenty days.

Patient feedback was mixed. It should be noted that digital provision is only one treatment option, not a replacement for face-to-face services. Almost half of service users thought online appointments were worse than in-person, with only 28.6% of patients judging it was better. Older groups in particular, found digital communication difficult to use.

Mind's survey of 1,914 people in December 2020 (Mind, 2021) found that whilst there were advantages, a quarter felt their mental health had deteriorated having used phone or online support.

Accessing digital services is a further challenge. Lloyds Bank's Consumer Digital Index (2020) estimates 4.8 million people never go online and 11.3 million lack basic skills to use the internet.

Flexible services

The main patient advantage – that of flexibly timed provision – was not typically offered by NHS providers in 2020. They tended to use technology to offer the same appointments at the same time (working hours) but just on a videocall rather than in person, whereas other health care providers have used digital technology to create more flexible treatment offers.

Figures from Acacium's digital service – which responds to patient demand – show that half of its online therapy appointments are delivered outside normal hours: 19% at the weekend; 30% between 5-11pm Monday to Friday. Kooth, the online provider of digital support to young people, is available from noon to 10pm on weekdays and 6pm to 10pm at weekends to fit around school timetables.

This is both cost effective and popular.

- Clinics can be delivered from a therapist's home directly to a patient's kitchen without the expense of opening offices, buildings and clinics in the evening and at the weekend. Both save on travel times.
- Online support makes the geographic origin of the counsellor or therapist irrelevant. Using digital technology, someone in Australia can offer online support to a resident of Bradford or Stockholm or Sydney at the same cost – they just beam in. This enables health providers to expand their workforce easily and instantly, and reduces the cost of international recruitment.

- Out-of-hours provision enables a patient with a job to access therapy without having to book annual leave. Employment and education are core mental health protective factors. Young people can receive treatment without missing school or college.
- People living in remote communities or who find travelling difficult (for example because of costs or panic attacks on public transport), can circumvent distance, cost and anxiety.
- Digital technology opens up new forms of communication: text and instant messaging. This may appeal to children and young people as an alternative to in-person treatment.
- Apps have been developed which successfully help screen and enhance wellbeing and mental health, particularly in the measurement and management of anxiety. These are low cost and highly replicable.

Increasing staff productivity

It is virtually impossible for NHS staff to work for a number of trusts at the same time. 'Passporting' clinicians to work for a range of trusts via digital communication would enable clinicians to deliver treatment flexibly. A video call appointment for a patient in Bromley, followed by Peterborough, finishing in Cumbria is easy on Zoom, and should be possible for any NHS employee.

A passport scheme would mean that NHS staff can respond to local surges in demand without having to travel. This means staff are deployed where needed, making them more productive.

As the Leeds and York report (Jackson & Saeidi, 2020) noted, a dominant benefit of digital technology was better work-life balance and better productivity for staff, with flexible working and autonomy being the most popular benefits.

Costs and benefits

Firm analysis of the costs and benefits of digital technology in the NHS is currently unavailable. However, much of the investment in digital infrastructure is already in place, which means it is the measurement of the results and benefits which is key. Specifically:

- Staff retention
- Staff productivity
- Did Not Attend rates for patients
- Treatment outcomes for digital provision.

Existing data suggests that the key economic savings accrue in the provision of out-of-hours services. It is popular with many patients and enables flexible working and access to international labour markets in order to meet treatment need. There is a clear opportunity for the NHS to grasp this opportunity and begin to match the offers of other health care providers in a new way.

If the offer of flexible working through increased use of technology meant that half the NHS clinical staff who would have resigned for reasons of work-life balance remained in post, it would retain 750 clinical staff each year within the mental health system.

What discernible difference would this achieve?

Successful deployment of digital technology offers an increased range of treatment options; choice which is good for patients and staff. Having participated in a national Zoom experiment, drawing lessons from what worked is a significant opportunity for the NHS.

Conclusion

The demand for evening and weekend support, combined with the ability of digital technology to supply flexible labour is a big win. Staff and patient feedback is mixed. Digital therefore enhances delivery options rather than replaces them.

6. Keeping NHS staff well

Systemic issue

- Enhancing, protecting and treating NHS staff health is crucial to providing great health care by preventing absenteeism, lower productivity and staff shortages.
- In July 2020, a third of all NHS staff absences were due to stress, anxiety or mental health problems. This consistently represents over 25% of total absences (NHS Digital, 2021c).
- A healthy workforce requires strategic investment in support, particularly in the wake of a pandemic.

Argument and substantiation

Pre-Covid, levels of mental illness were high amongst NHS staff.

Pre-pandemic research estimates prevalence of psychiatric morbidity amongst doctors ranged from 17% to 52%. Burnout scores for emotional exhaustion ranged from 31% to 54.3%, and low personal accomplishment from 6% to 39.6% (Imo, 2017).

Total absences (all reasons) among clinical staff fluctuated between 4% and 5% between 2015 and February 2020, with depression and anxiety being the most cited reasons.

Figures during the pandemic show an increased absence rate of 6.2% during the first wave which was driven by staff contracting Covid-19. Absences declined over the summer, rising steadily from September to 5.7% in January 2021 when Covid-19 was again a key factor.

But as absences rose, mental health driven reasons for absence have remained consistently at 25% or above for clinical staff (with the exception of March and April 2020, and January 2021).

In short, absences for mental health reasons are increasing in real terms – significantly.

And absences are only one vector of poor health; lower productivity, poorer morale and ultimately patient care being three others. These measures are unpublished.

Centre for Mental Health's forecast of mental health demand resulting from Covid-19 calculates that the 13,000 staff who worked in ICUs treating Covid patients in 2020/21 are likely to face high levels of PTSD (40%), severe depression (6%) and anxiety (11%) in addition to existing health problems (O'Shea, 2021). Frontline workers – of which there are over 1.07million - also face high rates of anxiety, depression and PTSD as a result of the care and treatment they have provided. The pandemic will result in worsening mental health for NHS staff – something which is already being observed in absenteeism figures.

The resulting system failure

There is an absence of strategic planning for how to promote and protect the health of NHS workers, including during and post-pandemic.

The Covid-19 mental health and wellbeing recovery action plan only commits to £30m of specific funding – approximately £30 per NHS staff member – on mental health hubs. NHS staff have accessed the health and wellbeing offer 750,000 times but the outcomes of that or the number of contacts per person are unpublished.

Proposed solution

A funded strategy for the mental health of NHS staff that:

- Quantifies current health needs across all NHS staff
- Estimates mental illness that will result from the pandemic
- Offers structured investment in prevention, treatment and recovery for both
- Is culturally aware and in some cases culturally specific
- Offers help to all staff – physicians, auxiliary staff and support teams
- Builds on the **NHS People Plan**.

Its design should reflect the framework of enhancement, prevention, management, crisis and recovery and link to clear goals, with an accompanying evaluation to determine impact.

Argument and substantiation

There are examples of good practice, such as:

- Tees, Esk and Wear Valleys NHS Foundation Trust offers a staff mindfulness programme, an Employee Psychology Service and trust retreats.
- Greater Manchester's Resilience Hub was created following the Manchester Arena bombing and has been developed to offer screening and support to NHS staff and their families. This is an example of NHS England's Mental Health Hubs which is an emerging programme offering local support and national telephone helplines.
- 'Supporting our NHS People' from NHS England, which offers coaching, support helplines and a wellbeing app.

However, whilst these are examples of support and assistance, it is not a functioning system of consistent, considered and timely psychological treatment which is delivered across all NHS organisations with an agreed outcome of keeping staff mentally healthy.

The existing commitment in the NHS People Plan (NHS England, 2020) states:

"*Psychological support and treatment: Employers should ensure that all their people have access to psychological support. NHS England and NHS Improvement will continue to provide and evaluate the national health and wellbeing programme developed throughout the COVID-19 response.*

NHS England and NHS Improvement will also pilot an approach to improving staff mental health by establishing resilience hubs working in partnership with occupational health programmes to undertake proactive outreach and assessment, and co-ordinate referrals to appropriate treatment and support for a range of needs."

A national strategy would detail how it will identify, support and treat the predicted 5,325 ICU staff who will have PTSD, or the estimated 250,000 front line workers who will require treatment for severe depression or anxiety. The provision of screening and large-scale clinical treatment for traumatised staff can only be delivered with a clear strategy for investment.

The cost of NHS staffing was £47.6bn in 2016/17 (King's Fund, 2019). Preventing a 1% increase in the rate of FTE absence saves £476,000,000 per annum. This is the equivalent of providing a quarter of a million staff with mental health treatment worth approximately £2,000 per person as a breakeven exercise to reduce staff absence.

This is the kind of spending envelope for staff treatment and support that should be under consideration and the levels of funding that a strategy should offer.

Conclusion

Health care staff need to be healthy in order to provide excellent health care.

This requires an investment strategy for treatment which aims to protect, enhance and improve the mental health and wellbeing of NHS staff.

The absence of one risks high levels of staff shortages through absenteeism and resignations.

A strategy should commit the cost of a 1% increase in staff absences to treating staff recovery.

7. Linking physical and mental health care

Systemic issue

- 'Healthy mind in a healthy body' was a phrase coined by the Roman, Juvenal, around 85AD. He saw a link between the two.
- 2000 years later, NHS treatments for physical and mental illness are delivered to the same patient through two completely different systems which rarely communicate or collaborate.
- The life expectancy of someone with severe mental illness is 15-20 years shorter than average. Mental illness leads needlessly to early death from physical causes.

Argument and substantiation

Mental and physical health are synonymous.

Good physical health aids good mental health. As the Department of Health and Social Care have noted, "There is clear evidence that physical activity reduces the risk of depression" (Department of Health, 2011). For those over 65, daily activity reduces the risk of depression and dementia by 20-30%.

Public interest in this link is also significant. Wendi Suziki's TED talk on 'the brain-changing effects of exercise' has 6.4m views on YouTube. Joe Wicks' pandemic response videos include 'Mental Health Through Fitness' (108k views), and 'Struggling with my mental health' (122k views).

Conversely, poor mental health results in early deaths. *Improving the Physical Health of Adults with Severe Mental Illness* (Royal College of Psychiatrists, 2016), published by a collaboration of Public Health England and all the medical Royal Colleges, describes the problems related to fractured care and the practical solutions. It does so in great detail, including how the Royal Colleges and Societies can have a leading role in improving the physical health of people with mental illnesses.

Its foreword by the then Chief Medical Officer, Professor Dame Sally Davies, notes:

"My Chief Medical Officer report in 2013 on mental healthcare priorities highlighted, among many other things, the barriers between physical and mental healthcare and how these can detract from satisfactory healthcare delivery, particularly for patients with severe mental illness. There remain barriers in training, healthcare delivery and research. Furthermore, there are major differences in the life expectancy of people with severe mental illness. These differences must be addressed urgently."

Yet despite articulate case-making, practical ideas for delivery and highly-respected institutions and colleges recommending this, examples of holistic treatment (mind, body, spirit) remain rare.

There are also challenges within the primary care workforce. In 2018, Mind reported findings that suggested that 46% of trainee GPs undertook training placements in mental health settings where the only option available was a psychiatric hospital or secondary care placement. 82% of practice nurses felt ill-equipped to deal with aspects of mental health. 42% reported having received no mental health training at all (Mind, 2018).

The resulting system failure

- People with severe mental illness die earlier than those who don't
- Medically unexplained symptoms are common, accounting for up to 45% of all GP appointments (NHS UK, 2021)
- 10 million appointments per year are for patients repeatedly presenting with unexplained health problems at a cost of approximately £340m per annum.

Proposed solution

Programmes which treat mental and physical illness at the same time demonstrate improved patient outcomes and value for money, building on the success of programmes such as SCIMITAR+ (Gilbody *et al.*, 2019) which achieved effective smoking cessation for people with severe mental illness.

Argument and substantiation

There are a number of examples of this approach. The Primary Care Psychological Medicine (PCPM) programme operates in Rushcliffe, Nottingham, and is an example where success is substantiated by data. It offers psychological interventions in GP surgeries for people who use high levels of health care because they have unexplained or persistent physical symptoms of illness (see O'Shea, 2019). The theory is that offering a psychological intervention will identify and resolve the root causes of unusually high levels of physical health problems. This will result in a reduction in demand for primary and secondary care.

Costs and resources required (capital, revenue, staff):

The initial team costs were £153k in staffing, plus £57k in overheads and central costs.

Benefits

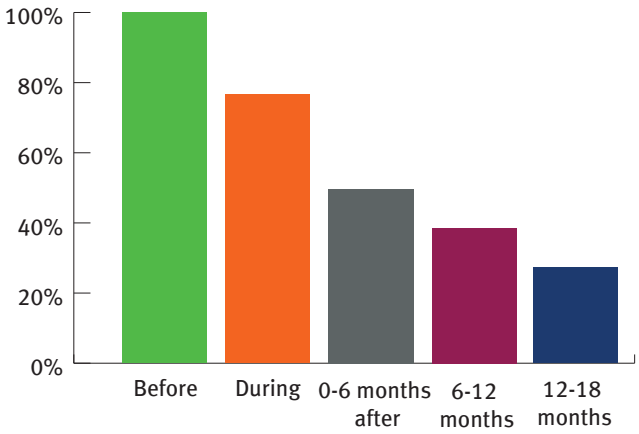
The most recent data from the programme shows it has a consistent and lasting impact on use of medical services.

Net benefits

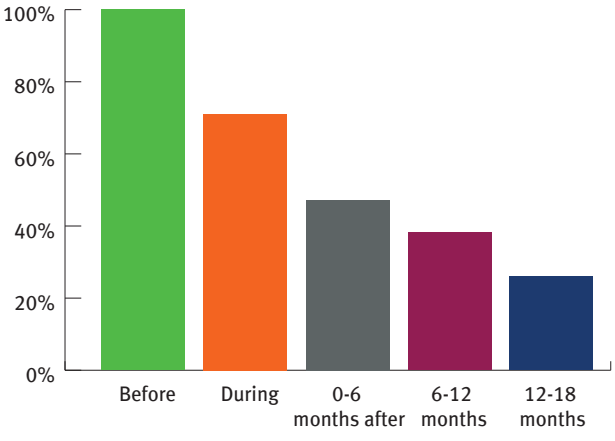
New services often take many years to demonstrate a saving, yet in its first phase PCPM is able to evidence reductions in health care use of £153,566 (greater than the staffing costs of the programme) and, very tentatively, show annualised, post-discharge savings of £524 per person. This was through reductions in emergency and secondary care.

Since the first evaluation, use of health care by participants continues to fall consistently over time, as the graphs below illustrate.

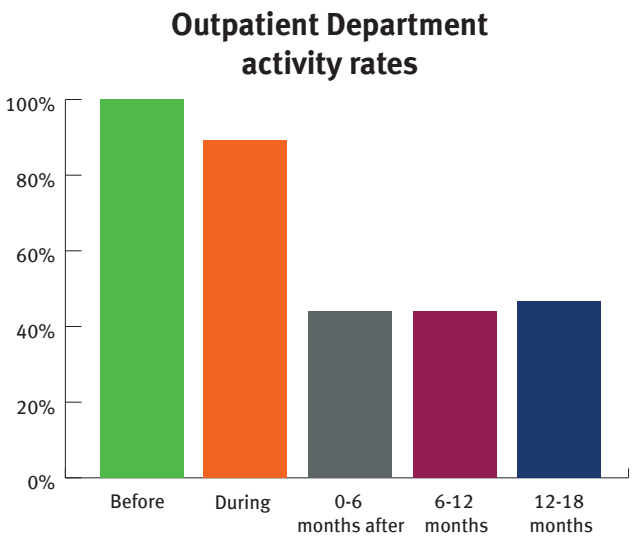
Inpatient activity rates

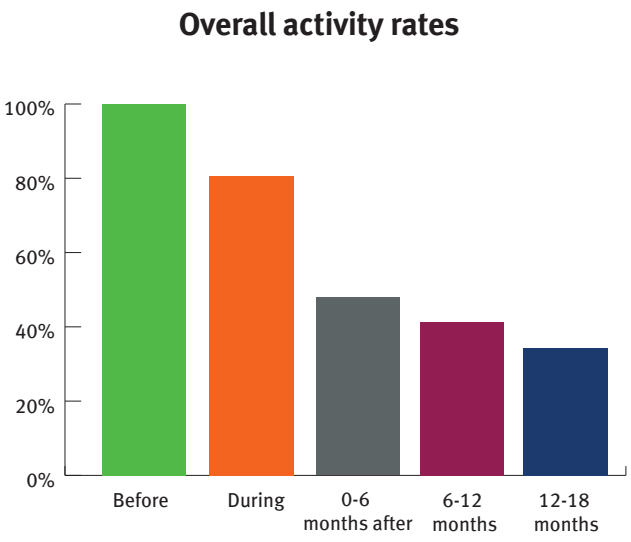


Emergency Department and Urgent Care Centre activity rates



Source: Schofield (2021)





Source: Schofield (2021)

What discernible difference would this achieve?

The PCPM programme has recently been expanded from one to six areas. The resulting data will demonstrate the impact on service use and patient outcomes. If it continues to achieve the same levels of success it will:

- Improve the physical outcomes for patients by offering mental health support
- Reduce use of secondary and emergency care
- Demonstrate a net saving in health care use.

Conclusion

Programmes such as PCPM demonstrate that because mental and physical health are linked, there are clear patient and financial benefits to treating them together.

Ultimately, all health services should ask the same question – did the patient recover? Are they better?

8. Investment in information governance

Systemic issue

- Individual trusts, CCGs and national offices each interpret and determine their own information governance systems
- Some patient data is held electronically, some on paper
- The NHS has limited national capability to track patient journeys or identify groups of patients where case coordination approaches would reduce costs and improve outcomes. This is crucial information
- Recent developments have continued the move away from a national system towards one where data is held by organisations which are distinct from the NHS.

Argument and substantiation

Patient data is precious. The Data Protection Act places firm obligations on all NHS organisations to share data consensually, proportionately, and/or anonymously.

A central service – The NHS Care Records Service – was established in 2005 but abandoned in 2013. It was designed to create a patient journey database that would link GP surgeries and hospitals, directly owned and run by the NHS.

Although there was no direct replacement, eight Commissioning Support Units (CSUs) were formed to offer back-office functions to Clinical Commissioning Groups (CCGs), including contracting, recruitment, procurement, and outsourcing. This includes the collection, analysis and sharing of patient data. In some cases, CCGs have outsourced patient data sharing to CSUs.

The precise architecture of these organisations – three private companies and five which identify as part of the NHS – is varied. Of those that are viewed as part of the NHS, there are no published accounts, annual reports, non-executive oversight or published renumeration figures. It is unclear if the organisations generate a surplus and what happens to it.

In December 2020, South Warwickshire NHS Foundation Trust announced it was forming the first NHS Digital Innovation Hub. Launched personally by the then Secretary of State for Health, Matt Hancock, the Hub is being delivered in partnership with SCC, Europe's biggest independent IT solutions provider.

The Trust notes "The aim of the Digital Innovation Hub is to provide clinicians with a real-world, co-creative facility that will accelerate the identification and development of digital care solutions with opportunities to perform on-going trials of new technologies" (South Warwickshire NHS Foundation Trust, 2020).

Subsequently, in April 2021, the trust announced that it would consolidate all the information governance and access to medical records teams within the Foundation Group into a subsidiary company called Innovate. Though owned by South Warwickshire Foundation Trust, it will be an independent company.

The resulting system failure

- The current NHS data-sharing landscape is more complex than a decade ago. With this comes risks
- Plans for a National Care Records Service within the NHS were disbanded in 2013
- Data is moving into multiple companies which are not a direct part of the NHS
- This creates a system where data is not held centrally by the NHS.

Proposed solution

Re-examine the idea of a National Care Records service which digitises all patient journeys and keeps this information centrally and under the direct control of the NHS. This would:

- Enable the NHS to understand patterns of patient journeys
- Compare regional performance
- Understand the overlap of mental and physical health care use for patients
- Keep patient data – which is valuable – within the NHS.

Argument and substantiation

There are two further advantages which would help control costs within the NHS:

1. The identification of high-cost patients within ICS areas. For 'high cost, poor outcome' patients – for example those who have multiple GP appointments for unexplained pain which continues to be unresolved – a case coordination approach would enable the NHS to ask, "does your current treatment result in the best possible outcomes for you?". This would be particularly helpful in identifying and reducing unnecessary acute bed costs.
2. Match spending to outcomes in order to determine value for money and return on investment metrics. By understanding the range of emergency, secondary and primary treatment, calculating the associated costs, and quantifying metrics such as recovery rates it would become possible to measure cost per outcomes, which is crucial to making investment decisions.

EY estimated that the value of a curated NHS data set could be as much as £5bn per annum, delivering around £4.6bn worth of benefit to patients per annum (Wayman and Hunerlach, 2020): "The value to patients would come from potential operational savings for the NHS, enhanced patient outcomes and the generation of wider economic benefits to the UK."

However, the fragmentation of data between numerous trusts means "in reality, the NHS health care data ecosystem is made up of multiple fragmented and geographically dispersed data silos. Each data set contains multiple data types and formats" (Wayman and Hunerlach, 2020).

This restricts its use, value, and ability to model national treatment programmes based on need and return on investment.

Conclusion

Whilst proceeding with extreme caution, understanding the entire patient journey is crucial to determining how treatment improves health. A digital database of patient information would achieve this, but is accompanied by the large risk of such a valuable dataset being misused, sold or corrupted.

9. Investment in outcome measurement

Systemic issue

- The NHS does not measure the total cost of a patient's treatment
- It does not measure patient outcomes – such as recovery – across its services with consistent metrics
- The focus of measurement is often on outputs, such as bed days, and good outcome frameworks are confined to specific services
- The result is that value for money and return on investment cannot be calculated
- Investment in services is not determined by outcomes, value or return on investment.

Argument and substantiation

The unit cost of treatment data collated and published by NHS Digital is helpful in determining the average cost of a wide range of patient health care. It is useful to know the unit cost of a bed, or the average cost of psychosis treatment; however, it only shows the number of procedures and the average cost.

It does not link this to:

- An outcomes framework – has the person made a full recovery? Did the treatment work? Have they got a job, a home and a loving relationship?
- Demographic information – do different genders, communities and age groups have significantly different access and outcomes?
- What were the outcomes of those who did not have a successful referral to IAPT and of those who did not complete the therapy?

What gets measured is what gets managed. Outcome and patient cost are two crucial data requirements for ascertaining what government spending achieves.

The resulting system failure

£13.3bn is spent on mental health care annually, for which (excluding IAPT, EIP and children's eating disorders) there is:

- No agreed measure of success across services;
- No way of matching spend to outcomes;
- No method to identify groups of high-cost patients with poor outcomes;
- No link between physical and mental health outcomes.

Proposed solution

An outcomes framework which measures the same outcomes across a patient's treatment.

Specifically:

- Life expectancy
- Physical and mental health outcomes simultaneously
- Treatment outcomes – recovery versus ongoing treatment
- Cost per patient
- Impact on overall wellbeing, as well as mental health.

Whilst services such as IAPT demonstrate how recovery outcomes can successfully determine value for money and patient experience, additional gaps in IAPT data also require resolution; primarily, measuring the health outcomes of people who are referred to IAPT but assessed as being ineligible for treatment, or what happens to people who do not complete the course of therapy.

Argument and substantiation

Life expectancy (reduction in avoidable deaths)

During the period of 2017 to 2019, the gap in life expectancy at birth between some local areas of the UK was 9.4 years for men and 7.6 years for women (Pratt, 2021).

In 2008, the London Health Observatory showed that travelling eastbound on the Tube from Westminster, every two Tube stops represented more than a year of life expectancy lost. Analysis (Cheshire, 2012) found a 20-year difference in life expectancy between those born near Oxford Circus and others born close to some stations on the Docklands Light Railway (DLR).

Whilst these disparities exist, this is the optimal measure of health being strongly correlated with wealth, education, living standards and ethnicity.

Measurement of life expectancy is a defining success of a health care system, as are targets to increase lifespan in areas where it is comparatively short.

For people with mental illnesses, we know that life expectancy is vastly shorter. Equally Well UK highlights:

- The life expectancy of someone living with schizophrenia in the UK is some 15-20 years shorter than someone without a mental illness. It is equivalent to the average life expectancy in the UK in the 1950s.
- Premature mortality among people with a mental illness is predominantly caused by poor physical health, by conditions such as diabetes, heart disease and cancer (Equally Well UK, 2021).

Life expectancy is therefore an obvious metric on which to base any health outcome framework.

Cost per patient and link to outcomes

HM Treasury assess investment cases based on the return on investment:

Return on investment =
value of outcomes / cost of investment

This requires:

a. **Outcome data**, such as recovery, treatment completion, improvement in mental health, all of which are routinely measurable. By way of example, a comprehensive indicator framework for health – including process, output and outcome indictors – can be found here on page 180 of the Marmot Review (2010).

b. **Cost per intervention.** This is comprehensively captured by the NHS in its National Cost Collection work (NHS England and NHS Improvement, 2021).

c. **Cost per patient.** This is as yet not collected. Only when this is understood can return on investment be calculated. Even with IAPT, where outcomes and unit cost data are captured, there is no way to know how much additional health care was received by each patient. It is entirely plausible that outcomes observed by those completing IAPT could be partially explained by other mental health care treatment, such as medication.

Conclusion

Return on investment is crucial for any government spending commitment. If £X is invested, £Y worth of outcomes should be generated. Investment in NHS mental health treatment would be made much more attractive if investment could be linked to improvements in patient outcomes which were objectively and consistently measured across the range of services used.

10. Interagency working

Systemic issue

- Supply of publicly funded organisations is plentiful
- In addition to the 1,311 organisations within the NHS, there are a further 398 councils, 43 police forces, 41 Police and Crime Commissioners, 24 metro mayors, 533 English constituencies and 15 government departments. There are also 1,500 housing associations
- Each has their own governance, regulation, geographic boundaries, financial conduct and, in some cases, democratic mandate
- The complexity of this network of public services makes interagency collaboration a challenge
- There is not a unifying structure, common to public organisations, that enables them to share information and investment in a systematic way.

Argument and substantiation

Finding and funding appropriate housing for people with acute mental health problems illustrates the challenge. The typical unit cost of someone staying in high dependency service provision for mental illness or psychosis is £827 per day. An average mental health care bed is £424 per day (Curtis & Burns, 2020). There are delays to discharging patients when suitable accommodation is not available; particularly where there is not an intermediate offer of accommodation with high levels of support. This causes overuse of acute beds, increases costs and stops patients returning to the community.

- **Who will pay?**
  Since the Lunacy Act in 1845, there has been an unresolved tension between health boards, local authorities and individuals about who would fund the patient after being discharged. There is an arbitrary line between what is health and what is care; neither of which are defined in law.
- **Will you change your policy?**
  Who gets housed by a local authority is determined by their local allocation policy. Each one is different and is set by councillors. Apart from lobbying elected members, there is no mechanism for the NHS to seek changes to the policies.
- **Can we finance this?**
  Mental health trusts have begun to examine how to finance their own housing to meet need and cut acute bed use. This is an entirely new area for trusts and only one, Hampshire, has a director of housing. Finance is a challenge. For example, as that director notes, NHS England grants for housing place a charge on the property built – NHSE is the owner. Housing associations will not build houses that they will not own. Grants from Homes England do not have this condition but are not large enough to build the kind of accommodation needed. Solutions such as combining grants are not possible, because the issue of who owns the resulting property remains unresolved.
- **What about the boundaries?**
  Rarely are boundaries between the key organisations coterminous, which means different patients under the same foundation trusts require interagency working with entirely different organisations.

The resulting system failure

Between 2014 and 2016, out of area acute beds for adults with mental health difficulties increased by 40%, from 4,214 to 5,876, with reported annual costs of £159m per year. A lack of suitable, alternative accommodation is a reason for this. The same funding could have been used to create this type of supported accommodation. Instead, examples of this remain vanishingly rare.

Proposed solution

A common funding framework to give state organisations an agreed way to easily merge funding and share the savings.

Large spending reductions across the health, housing and social care sectors could be achieved. Without collaborations, these savings are unlikely to be realised.

For example, a collaboration that would enable Foundation Trusts (or ICSs) to successfully collaborate with local authorities and housing associations could create more step-down accommodation and reduce length of stay in acute wards. The forthcoming Health and Care Bill is a first opportunity to do this.

Argument and substantiation

Financial modelling by Centre for Mental Health calculates that a 15-bed unit offering a 3-month programme of transitional care from an acute setting to community accommodation would generate net savings of £7.46m per year. Every £1 invested resulted in an average net saving of £5.62 (ROI: 6.62:1). There are clear and large financial savings to be made.

Costs

A national programme of step-down residential care would offer 12,000 places: roughly 10% of patients staying in acute care. With approximately 120 people per site, per annum, 100 sites (costed at £668k per site per annum) would have a total cost of £66.8m.

Benefits

Gross saving of: £442m per annum.

Net Benefits

Net saving of: £375m per annum.

Conclusion

Housing is one example of where interagency working could unlock sizeable financial savings whilst improving the outcomes of people with mental health difficulties. There are parallel examples in criminal justice, drugs and alcohol services, support during family breakdown and education. Schools, colleges and universities offer excellent examples of collaboration to improve student health.

This requires agreed ways to easily pool budgets, responsibility, and risk; plus, an agreed way to share the savings and rewards. Initiatives, such as Cabinet Office Future Leaders Academy, also illustrate the benefits of proactively fostering relationships across systems.

Conclusion

Our mental health system has many advantages – not least a committed workforce and more recently, significant voter interest in our mental health. But there are some clear, structural reforms required to enhance the outcomes from existing resources and skilfully direct new investment to maximise results.

At the core of mental health care provision is how we perceive those with poor mental health. When 19th century law sought to retrospectively create a system around an industry of asylums, it did so in terms of the deserving and undeserving citizens. It 'baked in' many of the problems policymakers still negotiate around public safety, public finance, private segregation and patient choice. Ultimately, it failed to determine whether mental health care offers recovery or palliative care and questioned if patients deserved either.

Covid presents an opportunity for fresh thinking because in the midst of a pandemic, we have seen that so much is possible. Digital transformation has been shown to be instant; ten-year plans have taken ten days without costing millions; health and social care have worked with unparalleled collaboration; and young people want to be nurses again. Sustaining those gains is now the challenge.

Simple reforms are needed to judge the worth of investment and make a business case for future finance. Return on investment cannot be calculated without outcome measurement and tracking patient costs. The absence of this data makes HM Treasury uneasy and their chequebooks harder to prize open. Similarly, the inability to quantify billions of spending on system failures – such as delayed discharge – highlights the target for saving money but offers no route to achieve it. Finally, aligning funding regulations to enable joint investment would be quick and lucrative, as would digitised patient records.

The NHS was conceived because a post-war government understood the need to share the capricious risk of illness through the certainty of collective taxes. Whilst this has worked wonders for our physical health, successive attempts to reap the same rewards for mental health care have been incomparable.

Ultimately, this is a time of choice. We can fling borrowed money at a wall built in 1845 and hope something changes. Or we can seize the moment and integrate a system to genuinely establish parity of care for mental health.

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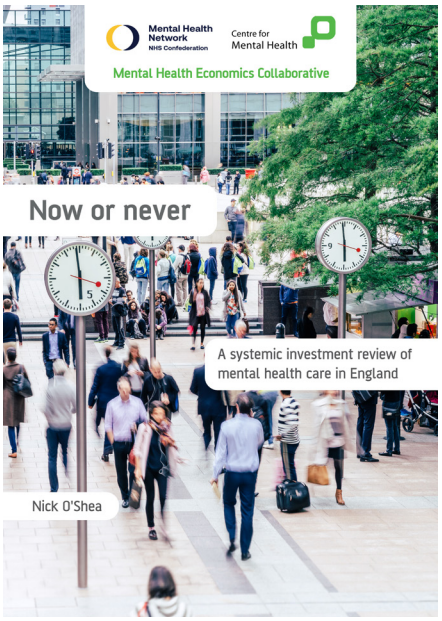

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