

# Briefing

## Mental health under pressure

### Key messages

- An absence of robust data makes it difficult to provide a definitive assessment of the state of mental health services. What is clear is that it is a sector under huge pressure. While increased political support and a stronger policy focus is welcome, parity of esteem for mental health remains a long way off.
- Funding for mental health services has been cut in recent years. Our analysis shows that around 40 per cent of mental health trusts experienced reductions in income in 2013/14 and 2014/15.
- There is widespread evidence of poor-quality care. Only 14 per cent of patients say that they received appropriate care in a crisis, and there has been an increase in the number of patients who report a poor experience of community mental health care.
- Bed occupancy in inpatient facilities is frequently well above recommended levels, with community services, in particular crisis resolution and home treatment teams, often unable to provide sufficient levels of support to compensate for reductions in beds. This is having a negative impact on safety and quality of care.
- The lack of available beds is leading to high numbers of out-of-area placements for inpatients. Out-of-area placements are costly, have a detrimental impact on the experience of patients and are associated with an increased risk of suicide.
- In recent years, mental health providers have embarked on transformation programmes to implement large-scale changes to services, workforce and corporate infrastructure.
- These programmes have been based on reducing costs, shifting demand away from acute services, and delivering care focused on recovery and self-management.
- This has seen reconfiguration of the evidence-based services implemented under previous national programmes, notably the National Service Framework for Mental Health, in favour of care pathways and models of care in which the evidence base on what works is often limited. These initiatives represent a leap in the dark, with little formal evaluation to indicate impact on the quality of or access to care.
- These transformation programmes have usually resulted in cost reductions and have prevented many mental health providers from falling into deficit. This may

have come at the expense of patient care. There is evidence of increased variation in care and reduced access to services as a result of the changes.

- These transformation programmes have also resulted in far-reaching changes to the mental health workforce and have led to a significant reduction in the number of experienced nurses. This has resulted in staff shortages and insufficient staff skill mix in some areas of care.
- As their financial position deteriorates, many mental health trusts are considering another wave of large-scale changes. This risks destabilising services further and reducing the quality of care for patients.
- There is a clear need for mental health services to focus on using evidence to improve practice and reduce variations in care. However, it is essential that this is underpinned by stable funding, with no more cuts to budgets.

## **Introduction**

Mental health services in England have a history of transformation – replacing long-stay institutions with care in the community, diversifying services to focus support on people with specific needs, and extending access to evidence-based mental health treatment to those in primary care. In recent years, a new wave of transformation programmes has emerged that aims to shift provision from a ‘medicalised’ system of delivering care and treatment to one that focuses on the principles of recovery, with services and the workforce redesigned to reflect that focus.

NHS England commissions mental health services at a national level, ensuring the provision of specialised care for the small groups of individuals who require it. Clinical commissioning groups (CCGs) and local authorities commission local provision for people in the community, who constitute the majority of those with mental health conditions; this also allows for the provision of support beyond that of health services.

The last population survey of mental health found that 17.6 per cent of the English population aged between 16 and 64 meet the criteria for one or more common mental health disorders, while 0.4 per cent experienced a psychotic disorder (McManus *et al* 2009). In 2014/15 1,835,996 people were in contact with mental health services – an increase of 4.9 per cent from 2013/14 (Health and Social Care Information Centre 2015b). Approximately 1 adult in 28 was in contact with secondary mental health services.

Ministerial support for mental health, from Norman Lamb among others, has resulted in a renewed focus on mental health policy. A government mandate for parity of esteem between physical and mental health (Department of Health 2013) has been followed by the identification of priority areas for improvement, and the subsequent introduction of access standards in line with those in the acute sector (Department of Health 2014). Each has sought to put mental health on an equal footing with physical health. However, voices from across the mental health sector are warning of a crisis.

Funding has been put at the heart of those concerns. There is a marked disparity between the level of funding for mental health services and the impact that mental health problems have at a population level, and there has been a notable reduction in funding to NHS

mental health providers since 2010/11. On the surface, however, the finances of NHS mental health providers are relatively healthy compared with those of acute providers.

Another area of concern is the quality of care. Stories highlighting examples of poor care and poor outcomes have dominated media coverage on mental health in recent years: patients waiting months for talking therapies, patients in crisis being told that there are no beds available, and patients receiving little or no support for physical health care conditions. These stories span all types of provision, and their frequency suggests that quality of care is a systemic issue.

## **Our briefing**

There can be little doubt that the mental health sector is under pressure, however understanding the nature of those pressures has been difficult. The mental health sector comprises a number of inter-related services covering a range of different conditions which together create a system of care. This briefing paper aims to focus on mental health as a system of care, examining individual pressures within the wider context of provider and commissioner actions. Although services for children and adolescents, and older people are very much part of this system of care, this briefing paper focuses on services for adults between the ages of 16 and 65.

Our analysis is based on a review of the literature, national datasets, survey data and analyses from other bodies, and data collected as part of our quarterly monitoring report survey. In addition, we have conducted new analyses of NHS provider board papers, annual reports and strategic plans. It is well established that the availability of robust data and national information on mental health services is limited and this means that quality of services cannot be definitively assessed (Dormon 2015). We have drawn together information from a number of different sources each of which provides a particular insight into provision and quality in order to provide an overview of the state of mental health services and care in England. In focusing on the pressures in mental health we have predominantly highlighted negative outcomes. This does not preclude that some pressures and actions have resulted in positive outcomes or that there are individual examples of good practice. Despite this there is little evidence that the pressures identified are only limited to specific areas of practice or individual providers, and many areas of pressure such as crisis care have been the subject of national focus and policy initiatives.

## **Crisis care**

One of the most important roles for mental health services is to support individuals in crisis. Although inpatient treatment gets considerable attention, crisis care incorporates a range of services to ensure that patients receive the most appropriate and least coercive treatment. Crisis resolution and home treatment (CRHT) teams play a particularly important role in providing intensive community support to people in crisis both to prevent admission and to facilitate prompt discharge. Crisis houses and similar services such as host families can provide alternative residential settings, and liaison psychiatry services provide specialist services to those who present at accident and emergency (A&E).

There has been a long-term reduction in the number of psychiatric beds in England, dropping from a peak of around 150,000 beds in 1955 to around 22,300 in 2012. Between 1998 and 2012 there was a 39 per cent reduction in the number of beds, with a 7 per cent reduction between 2010/11 and 2013/14 alone (The Commission on Acute Adult Psychiatric Care 2015). These reductions have been associated with a number of national policies (Imison *et al* 2014) – including implementation of guidelines on suicide reduction and standards for inpatient care – resulting in a move from large outdated hospitals to smaller purpose-built premises, and the development of specialist community teams under the National Service Framework, changes that promised reduced demand on inpatient services.

The need to replace old and unsuitable estate has continued to impact on inpatient capacity, and more recently bed reductions have been incorporated into local provider-driven systemic transformation plans. Crisis resolution and home treatment (CRHT) teams were implemented across the United Kingdom as part of the National Service Framework (Department of Health 1999). Recent service redesign has resulted in a reduction in CRHT teams operating as distinct services as defined by the original mental health implementation guidelines (UCL CORE Study 2014), and the merging of their specialist functions with generic community mental health teams (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2013). The model of care also been adapted with many teams performing a wider range of functions than originally outlined by the mental health implementation guidelines (UCL CORE Study 2014).

Despite ongoing bed closures, demand for inpatient beds has not reduced on a national scale. Over the past 10 to 15 years questions have been raised repeatedly about whether a minimum safe level of beds was reached (Bhugra 2013). Referrals to CRHT teams between 2011/12 and 2013/14 have also risen by 16 per cent (BBC News 2013). Demand seems to be outstripping capacity for urgent care in mental health services (The Health Foundation and Nuffield Trust 2014).

The Care Quality Commission's report on crisis care found that only 14 per cent of people who experienced a crisis felt that the care they received provided the right response and helped to resolve their crisis. The report concluded that a health and care system in which such a low proportion of people think they get the urgent help they need is unsafe and inherently unfair (Care Quality Commission 2015c).

Since 2009, detentions under the Mental Health Act have risen, with a 9.8 per cent increase in 2014/15 compared to the previous year (Health and Social Care Information Centre 2015a). More than a third of psychiatric trainees surveyed said that a colleague had used the Act to detain a patient knowing it would make provision of care more likely, while 24 per cent reported that bed managers had told them unless a patient had been sectioned they would not get a bed (Royal College of Psychiatrists 2014c). It has also been noted that the lack of available beds has negatively affected the completion of assessments for people detained in places of safety. Many of these factors are indicators of inadequate bed provision (Quirk and Lelliot 2001).

Pressures on inpatient facilities are also reflected in bed occupancy rates. The Royal College of Psychiatrists' recommended level of occupancy is 85 per cent (Royal College of

Psychiatrists 2010); however, a survey conducted by The Commission on Acute Adult Psychiatric Care (2015) found that of the 119 wards that responded, 91 per cent were operating above the recommended level, with some running at up to 138 per cent. Bed occupancy rates at more than 100 per cent generally occur when the beds of patients who are home on short-term leave are filled by new admissions, although inspections have also identified patients who had been admitted to hospital without a bed being available and seclusion rooms being used as bedrooms (McNicoll 2013c; Care Quality Commission 2014b). High bed occupancy runs counter to delivering quality and safe care (Royal College of Psychiatrists 2011), and levels 10 per cent above that recommended are associated with violent incidents on inpatient wards (Virtanen *et al* 2011).

When beds are unavailable locally patients are transferred to facilities outside their area. Experimental indicators developed by the Care Quality Commission and the Health and Social Care Information Centre found that in 2012/13 nationally 4.4 per cent and 4.9 per cent respectively of adult emergency admissions were potentially out of area (Care Quality Commission 2015c). A freedom of information (FOI) request by Community Care and BBC News on out-of-area placements found that among 37 NHS mental health providers, a total of 4,447 patients were sent out of area in 2014/15 – a figure up 23.1 per cent from the previous year (McNicoll 2015a). Among these, 88 per cent of cases were due to local beds being full. One of the leading private mental health service providers, Cygnet Healthcare, a major independent provider of psychiatric inpatient beds, also reported a 30 per cent increase in the number of NHS service users supported since 2011/12 due to reduced bed capacity (McNicoll 2013a). These figures are supported by the reports from frontline staff. In individual surveys of psychiatry trainees and approved mental health social workers more than 80 per cent of respondents in each group reported being forced to send someone out of area for a bed because of a shortage of local beds with many having had to do this on a regular basis (Royal College of Psychiatrists 2014c; McNicoll 2013b). Out-of-area placements not only impact negatively on patient experience, they have also been associated with increases in patient suicides (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2015a).

A Royal College of Psychiatry report described wards as overcrowded and understaffed, with 15 per cent of wards lacking segregated sleeping accommodation and fewer than 60 per cent having separate lounges for men and women (Royal College of Psychiatrists 2011). Patients and carers report that many acute wards are not always safe, therapeutic or conducive to recovery and in some cases could have a negative effect on an inpatient's wellbeing and mental health (The Commission on Acute Adult Psychiatric Care 2015).

Much of the pressure on beds can be attributed to insufficient support in the community and a lack of alternatives to hospital (The Commission on Acute Adult Psychiatric Care 2015). The UCL CORE study examined the operation of 75 CRHT teams across England and found that there was not a single area where the average performance across teams scored 'good' in relation to best practice. Performance was poorest in relation to being able to respond quickly to referrals and offer frequent visits. In 2014/15 the number of contacts CRHT teams had with patients fell by 6 per cent (Health and Social Care Information Centre 2015b). Particular concerns have been raised about the ability of CRHT teams to provide 24/7 support; the Care Quality Commission's work on acute care found that 65 per cent of organisations reported out-of-hours care was not of equal standard to

care provided at other times (Care Quality Commission 2015c). In England there are three times as many suicides under CRHT as in inpatient care; in 37 per cent of cases, the patient has been under CRHT for less than a week (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2015a). Although a greater proportion of patients are treated in the community, the inquiry questioned the ability of CRHT teams to provide adequate support and whether bed pressures had resulted in a greater number of patients at high risk of harm being treated by CRHT teams. The merging of specialist community teams has been associated with increased rates of suicide (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2013).

Timely access to support and care is essential for crisis care pathways. A substantial number of people who attend A&E multiple times are already known to mental health services, suggesting that if they struggle to get support elsewhere, many people seek help through A&E. Furthermore, many liaison psychiatry services in A&E are insufficiently resourced and providing an inadequate response (Barrett *et al* 2014; Care Quality Commission 2015c). CQC concluded that the system is struggling to provide the appropriate levels and quality of support. Issues include attitudes of staff to people presenting in crisis, access and availability, and the ability of services to deliver evidence-based care to meet the needs of their local population.

- Between 2011 and 2014 there was a 7 per cent reduction in the number of inpatient beds.
- A survey conducted by The Commission on Acute Adult Psychiatric Care found that 91 per cent of responding wards were operating above recommended levels of bed occupancy.
- An FOI request by Community Care found that use of out-of-area beds rose by almost a quarter in 2014/15.
- The UCL Core Study of crisis resolution and home treatment found that among the 75 teams surveyed, there was no single area of performance that could be rated as 'good'. Performance was poorest in responding quickly to referrals and offering frequent visits.

## **Community care**

Most people who receive support from mental health services do not require admission to hospital and are supported by mental health services in the community. Community mental health teams (CMHTs) are multidisciplinary teams who, in collaboration with service users, draw up a care plan covering the needs and goals of an individual, and co-ordinate care. Early intervention in psychosis services and assertive outreach teams (implemented alongside CRHT teams as part of the National Service Framework for Mental Health) are specialised community mental health teams focused on providing treatment and support for specific groups, the former for young people between the ages of 16 and 35 who are experiencing their first episode of psychosis, the latter for people with long-term mental health problems with more complex needs and requiring intensive support. The work of both teams is underpinned by specific models of care tailored to the particular needs of each groups. Voluntary and community sector services make a substantial contribution to supporting the wider needs of individuals in the community. Finally,

services commissioned under the Improving Access to Psychological Therapies (IAPT) programme provide access to evidence-based talking therapies for people with common mental health conditions in primary care services such as general practice.

Community services have undergone considerable reconfiguration in recent years including remodelling, decommissioning and integration. The majority of assertive outreach teams have been dismantled, with some functions integrated into community mental health teams (Firn *et al* 2013). The functions of early intervention teams remain more distinct, but again many have been integrated into community mental health teams (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2013).

Preparation for tariff-based payment systems has resulted in the reorganisation of service lines which take into account the new care pathway clusters (Whelan *et al* 2011). There has been a move away from individual service models and a focus on implementation of evidence-based National Institute for Health and Care Excellence (NICE) guidelines to clustering interventions and outcomes relevant to the patient characteristics captured within each of the 21 cluster groups. Trust strategic plans show that while some areas have embedded these changes in existing services such as community mental health teams, others have created new service structures. More recently a number of providers have moved towards a locality-based model of service delivery, rationalising existing community teams and developing smaller numbers of community hubs. These aim to integrate care more closely with primary care and other local provision, including voluntary and community sector services.

One of the most notable impacts on community services has been the move towards a recovery-orientated model of care. The recovery model emphasises the role of service users in defining their recovery in a way that is meaningful to them and agreeing the means by which they stay well and engage in a fulfilling life. Recovery-orientated care seeks to facilitate this, support shared decision-making, promote an individual's rights, and facilitate access to interventions as required. Many trust strategic plans outline recovery-orientated care as part of an increasing focus on delivering specific evidence-based interventions and facilitating service users to identify and engage in activities that support recovery and self-management. There is an expectation of time-limited intervention with prompt discharge to primary care and community services. While some trusts have developed services such as recovery colleges to support this, others describe the creation of a 'scaffolding' of support beyond statutory services. The role of community mental health teams in co-ordinating care is also changing, with some trusts moving the focus from care co-ordination to treatment and others advocating for flexible use of the Care Programme Approach, with the option to abandon it in some cases.

Community services play a key role in supporting people to manage mental health conditions. Any problems with community service provision can create significant pressures on acute mental health services. The Commission on Acute Adult Psychiatric Care (2015) found that 30 per cent of delayed discharges from hospital are associated with the absence of good-quality, well-resourced community teams (The Commission on Acute Adult Psychiatric Care 2015). Beyond hospital, there has been an increase in the number of people on Community Treatment Orders – a form of supervised discharge –

who are being re-admitted to hospital (Health and Social Care Information Centre 2014) and in the number of people repeatedly detained for assessment in a 90-day period under section 136 of the Mental Health Act (Care Quality Commission 2015c). Both have been flagged as evidence that people may not be receiving appropriate support from local services when discharged from hospital and that community mental health teams are struggling to provide appropriate care.

A survey of 96 of the 125 early intervention in psychosis services found that 53 per cent reported a decrease in the quality of their services in the past year (Rethink Mental Illness 2014), and despite Improving Access to Psychological Therapies' relative success in providing access to psychological interventions in primary care, a substantial proportion of people with severe mental health problems have had to wait for more than a year to access treatment and services are failing to provide sufficient access to the full breadth of evidence-based therapies recommended by NICE (Royal College of Psychiatrists 2014a).

In 2015, 28 per cent of people responding to the community mental health team survey rated their experience of community mental health care on a scale of 0 to 10 as 5 or lower (Care Quality Commission 2015a). This is compared with 25 per cent in 2014. Slightly higher proportions also reported not feeling listened to by staff, not feeling they were given enough time to discuss their needs and treatments, and not feeling that they were treated with dignity and respect compared with the previous year. The survey showed high degrees of variation in performance across trusts and although there were some improvements in people knowing who to contact about their care and medication reviews, the Deputy Chief Inspector of Hospitals, Paul Lelliott, concluded that overall there was 'no notable improvement' in people's experience of out-of-hospital mental health care.

- Thirty per cent of delayed discharges from psychiatric inpatient units are associated with the absence of good-quality, well-resourced community teams.
- In a survey of early intervention teams in 2014, 53 per cent reported a decrease in the quality of their services in the previous year.
- In 2014/15 there was an increase in people reporting a poorer experience of care in community mental health services. The Deputy Chief Inspector of Hospitals, Paul Lelliott, concluded that there was no notable improvement in people's experience of care.

## **Finances**

In 2012/13 primary care trusts spent £8.8 billion on mental health services: £7.08 billion of this funding was allocated to NHS providers and £1.72 billion (20 per cent) to independent and voluntary sector providers. In 2014/15 a reported £1.9 billion was spent on NHS services outside mental health trusts (NHS Clinical Commissioners 2015). Programme budgets for 2013/14 show that CCGs spent an average of 12.7 per cent of their total budget allocation on specialist mental health services (NHS England 2014a). Although variation between CCGs is influenced by a number of factors including prevalence of different disorders, there are clear discrepancies in funding allocation between CCGs with similar numbers of people with severe mental illness on the GP register (Public Health England 2015).

Historically, most mental health services are purchased through a block contract. Block contracts have been widely criticised as insufficiently reflecting the relationship between funding, activity and quality/outcomes. There is strong support across sectors for a reduction in block contracting for mental health (Mental Health Strategies and NHS Confederation Mental Health Network 2012). However, a survey of mental health trusts found that of the 19 respondents, only 5 per cent were planning to move to other types of contract in which cost is related to the volume of activity for 2015/16 (NHS Providers 2015a).

The national tariff is a fixed standard price paid for certain NHS services, which predominantly relates to inpatient care in mental health. Monitor, the sector regulator, reduced the national tariff for mental health and community trusts in 2014/15 by 1.6 per cent (Monitor and NHS England 2013). During this same period, additional funding has been agreed to support implementation of the access standards, representing an uplift in tariff prices of 0.35 per cent (NHS England Strategic Finance Team 2014). In practice, this still means a reduction of 1.25 per cent in the price paid for services despite the requirement to extend the scale and scope of provision in some areas. The NHS Providers survey (2015a) found that only 63 per cent of respondents were confident that their commissioners would offset the reduction in tariff prices by the full 0.35 per cent.

NHS England planning guidance for 2015/16 instructed commissioners to increase funding for mental health services for 2015/16 in proportion to their annual allocation of funding (NHS England Strategic Finance Team 2014). A survey of 67 CCGs found that 51 per cent planned to increase spending on mental health by 1 to 2 per cent in cash terms for 2015/16; 16 per cent said it would rise by less than 1 per cent; and 31 per cent said it would rise by more than 3 per cent (Lintern 2015). However, the NHS Providers survey (2015a) found that just 53 per cent of respondents were confident that commissioners would meet the guidance requirements. Providers were more confident that they were going to receive additional investment from CCGs than from NHS England local area teams, 77 per cent of respondents expecting to receive none of the additional allocation from the latter.

Funding for mental health (adult and older people's services) fell for the first time in a decade in 2011/12 by 1 per cent to £6.63 billion once inflation was taken into consideration (Mental Health Strategies 2012). Annual accounts show that between 2012/13 and 2013/14 44.8 per cent of mental health trusts experienced a reduction in income (Figure 1), although the following year this proportion fell to 38.6 per cent. This data, however, does not take into consideration the costs of inflation. An FOI request of 44 NHS mental health providers revealed a reduction of 2.36 per cent in real-terms funding between 2011/12 and 2013/14 (BBC News 2013).

**Figure 1** Percentage change in operating income for acute and mental health trusts



Source: Data extract of NHS trust annual accounts

Despite this financial disadvantage, 67 per cent of mental health trusts posted a surplus in 2012/13 and 2013/14, reducing to 58 per cent in 2014/15. The finances of mental health trusts present a stark contrast to those of acute trusts. Analysis by QualityWatch (2014) demonstrated that spending on mental health services for 2012/13 grew more slowly than on acute hospital care. Our analysis demonstrates that between 2011/12 and 2014/15 the majority of acute trusts received yearly increases in income, but unlike mental health trusts have increasingly gone into deficit, with less than a third of acute trusts in surplus by the end of 2014/15.

**Figure 2** Proportion of acute trusts and mental health trusts in surplus/deficit at the end of the financial year



Source: Data extract of NHS trust annual accounts

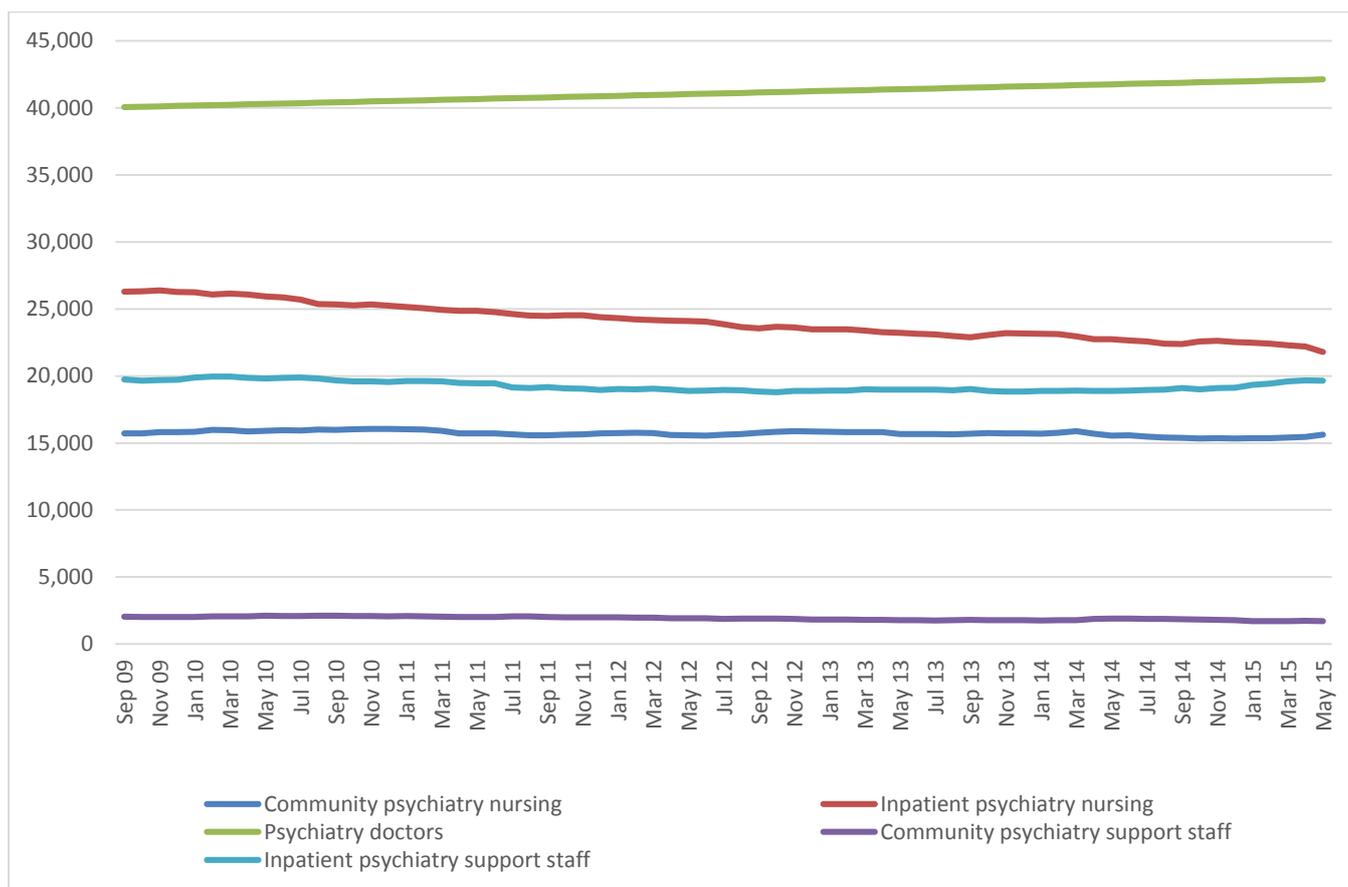
The last national data on funding allocation across mental health service provision was from 2011/12. This showed a decrease in spending on CRHT and assertive outreach teams but an increase in spending on early intervention in psychosis. An FOI request found that budgets for CRHT services had decreased in real terms by 1.7 per cent between 2011/12 and 2013/14 (McNicoll 2013d). Over the same period, spending for community mental health teams across 36 NHS mental health providers had decreased by 0.03 per cent in real terms. In 2014, a survey conducted by Rethink Mental Illness (2014) and the IRIS Network found that 50 per cent of early intervention in psychosis services had had their budget cut in the previous year, some by as much as 20 per cent. One of the largest voluntary sector mental health providers, Mind, reported a 5.7 per cent (£6.3 million) cut in funding for services (Lintern 2012). Data obtained from 23 trusts, however, found that funding for out-of-area placements has increased from £21.1 million in 2011/12 to £35.5 million in 2013/14 (McNicoll 2015b).

- Funding for mental health fell for the first time in a decade in 2011/12.
- Between 2012/13 and 2013/14 just 44.8 per cent of mental health trusts experienced a reduction in income, although the following year this proportion fell to 38.6 per cent. In contrast, more than 85 per cent of acute trusts have received annual increases in income.
- Over the past three years the majority of mental health trusts have been in financial surplus.
- Spending on services shows wide variation although there appears to be decreased spending on community mental health services and increased spending on out-of-area placements.

## **Workforce**

The mental health services workforce is largely composed of psychiatrists, psychologists, psychiatric nurses, and allied health professionals such as occupational therapists and health care assistants. Mental health services have seen a considerable change in both workforce numbers and skill mix. The National Service Framework resulted in large increases in staff numbers. Between 2003 and 2013 there has been a 41 per cent increase in full-time equivalent consultants (Smith *et al* 2015), with a 6 per cent increase since 2009 (Addicott *et al* 2015). This can be compared with a 48 per cent average consultant growth in other medical specialties in the same period. Between 2003 and 2013 the number of full-time equivalent clinical psychologists increased by 33 per cent. The implementation of IAPT also saw an increase in the workforce, although this was largely in therapists and wellbeing practitioners, with the majority of clinical provision drawn from existing staff.

**Figure 3** Numbers of FTE psychiatric staff, September 2009 to May 2015



Source: Health and Social Care Information Centre (2015c)

The nursing workforce shows a different picture. Between 2003 and 2013 there was a 2 per cent decline in the number of full-time equivalent mental health nurses, with some trusts cutting staff levels by more than 10 per cent (Royal College of Nursing 2014). Although this data does not take account of non-NHS providers, increases in non-NHS services are unlikely to be of a scale to offset such consistent declines in the NHS (Addicott *et al* 2015). Data for England shows a disproportionate drop in experienced nurses. Since 2010, the reduction in bed numbers has resulted in a 13 per cent decrease in nursing staff in psychiatric hospitals, with a limited number being re-deployed in community teams (Centre for Workforce Intelligence 2014). Integration and decommissioning of generic and specialist community teams led to an overall decrease in staffing, with specialists such as psychologists being spread more broadly across teams.

More recently, many strategic plans have placed a particular emphasis on workforce 'redesign', considering the resource and skill mix required to deliver new care pathways and recovery-orientated care. This redesign has seen a move to focusing specialist skills and time (for instance, medical and psychological) on clinical activities, including delivering evidence-based interventions. Alongside this is the development of a more generic workforce able to support recovery-focused provision. Plans indicated a change in the profile of the workforce, with reductions in specialist clinical staff and senior nurses, and an increase in junior nurses, allied health professionals and non-clinical roles including assistant practitioners, technicians, peer support workers and volunteers. This change in

staffing profile is reflected in the plans submitted by providers to Health Education England forecasting reduced demand for qualified nursing staff and responses to a survey by The King's Fund (Appleby *et al* 2014; Addicott *et al* 2015). Plans also reflect the redesigning of roles, including increases in nurse prescribers and physician associates, a requirement for staff to adopt more flexible roles in delivering care and the upskilling of non-clinical staff to fulfil wider roles. These changes are accompanied by a move to mobile or 'agile' working facilitated by IT developments, reducing the reliance on team bases and releasing time for greater patient contact.

Like the acute sector, many mental health services are experiencing problems with recruitment and high levels of vacancies, with increasing use of bank and agency staff (The Commission on Acute Adult Psychiatric Care 2015; Addicott *et al* 2015). Data collected by Mind and UCL showed that 41 mental health trusts had staffing levels below recommended benchmarks set by the Department of Health (Mind 2012), and requests for temporary mental health nursing staff have increased by two-thirds since the beginning of 2013/14 (Addicott *et al* 2015).

Appropriate staffing is particularly important in providing access to safe care, and it is clear that many of the changes in the mental health workforce have had a direct impact on the ability to deliver quality care. Staffing problems were identified as contributing to difficulties with accessing health-based places of safety (Care Quality Commission 2014a) and out-of-hours support for people with specialist needs. Staffing problems are also the most common reason for delayed assessment under the Mental Health Act (Care Quality Commission 2015c). Slightly more than half of the 75 CRHT teams surveyed by the UCL CORE study in 2013/14 had adequate staffing levels, and far fewer were able to provide a full multidisciplinary team, reducing their ability to resource more rounded support such as providing psychological interventions, supporting carers and preventing future crises for people in crisis. Insufficient staff with the right skills working out-of-hours (Care Quality Commission 2015c) and inconsistencies of staffing were also identified as having a negative impact on the quality of provision. Staff shortages, lack of availability of experienced staff and high staff turnover have been linked to deaths on inpatient wards (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2015b, c), and questions have been raised about how reductions in staff on inpatient wards relate to the rise in the number of patients detained for treatment (QualityWatch 2014).

Workforce capacity has also been identified as one of the key challenges in implementing the new access standards. A survey conducted by Rethink Mental Illness and the IRIS Network in 2014 found that 58 per cent of early intervention in psychosis services had lost staff in the previous year (Rethink Mental Illness 2014). Work on the early intervention in psychosis referral pathways has identified issues in meeting the required staffing levels and skill-set. Top requirements reported include having staff able to deliver psychological interventions, care co-ordinators, psychologists, vocational workers and psychiatrists. The review has found that insufficient staff numbers and limited skill-mix mean that no service currently has the capacity to deliver NICE-concordant services to more than 50 per cent of new first-episode cases by 2016 (Khan and Brabham 2015). These findings are unlikely to be unique; after three years of implementation, the number of trainees required to meet the requirements of IAPT fell, with two large health regions training almost no one (Centre

for Economic Performance Mental Health Policy Group 2012). The Commission on Acute Adult Psychiatric Care (2015) highlighted the need for an appropriate skill-mix of staff on wards and for investment in and training of frontline staff in inpatient settings to deliver a wider range of therapies and treatments. The Royal College of Nursing (2014) warned that reductions in the workforce have resulted in a widening gap between services needed and what is available on the ground.

Beyond the availability of appropriately skilled staff, The Commission on Acute Adult Psychiatric Care (2015) was struck by the variation in staff morale and wellbeing. High caseloads were among the areas that impacted on morale. Many of the issues identified by the Commission were attributed to a lack of properly trained staff with enough time to treat patients sensitively, with patience and empathy. Patients felt strongly that they wanted permanent staff with whom they could build a relationship. Despite the evidence of stress on staff, a survey found that fewer than half of NHS trusts had a plan or policy to promote staff wellbeing (Royal College of Physicians 2015).

- There has been a 2 per cent decline in the number of full-time equivalent nurses, with a particular reduction in the number of experienced nurses. This is unlikely to be accounted for by the increases in non-NHS provision.
- NHS England have reported that insufficient staff numbers and limited skill-mix mean that no service has the capacity to deliver the new access standards for early intervention in psychosis by 2016.
- The Commission on Acute Adult Psychiatric Care noted the negative impact of high caseloads and insufficient time on staffs' ability to treat patients sensitively, with patience and empathy.

## **Social care**

Since the era of de-institutionalisation, social care services have played a fundamental role in supporting people with mental health needs. Social workers operating within NHS services as part of a section 75 partnership agreement with local authorities are key to facilitating this access, in addition to providing a focus on the social aspects of mental health and in their legal safeguarding role.

There are significant challenges in meeting the workforce requirements in social care. A number of studies have highlighted a shortage of social workers in mental health services (Crosdale-Appleby 2014; Clifton and Thorley 2014). Furthermore, questions have been raised about both the quality of candidates coming through and the quality of social work education, with fewer than 8 per cent of students completing a placement in a mental health setting. The role of social workers within integrated teams has been denigrated, with many feeling devalued and de-professionalised (Clifton and Thorley 2014). In a study of staff morale in the mental health workforce, social workers scored significantly higher than other staff on emotional exhaustion (Johnson *et al* 2012) and the annual NHS Staff Survey in 2013 showed that social workers in mental health trusts suffered the highest recorded level of work-related stress since the survey started a decade previously (McNicoll 2014).

Access to social care has significantly decreased in recent years. The number of people receiving social care support for mental health problems has fallen by 25.5 per cent since 2009/10, but there is no evidence that the need for this sort of support has fallen (Dormon 2015). Cuts in local authority budgets have been identified by NHS trusts as having an adverse impact on their services (Appleby *et al* 2015).

It is important to note that the impact of local authority provision on mental health extends beyond social care to issues such as housing. The Commission on Acute Adult Psychiatric Care (2015) survey identified a lack of suitable housing as the key factor in 49 per cent of delayed discharges from hospital.

- The number of people receiving social care support for mental health problems has fallen by more than 25 per cent since 2009/10.
- In a survey of NHS mental health trusts, cuts in social care were noted to be having an adverse impact on their services.
- The Commission on Acute Adult Psychiatric Care identified a lack of suitable housing as a key factor in 49 per cent of delayed discharges from hospital.

## **Specialist services**

Specialist services account for 14 per cent of the total NHS budget. They include national eating disorder, gender identity, personality disorder, perinatal and deaf mental health services, in addition to services for people in the criminal justice system. Child and adolescent inpatient and secure services also comprise a core part of specialist services. All specialist services are commissioned by NHS England through local area teams.

In 2013/14 NHS England posted a £21 million (55 per cent) overspend for independent sector mental health providers and a £650,000 (0.06 per cent) overspend on NHS mental health providers (Calkin 2014a). Spending was associated with increased activity and a lack of NHS secure and specialist inpatient capacity. The NHS England Clinical Director of Specialised Services warned that the budget overspend could be as large as £900 million in 2014/15 (Lintern 2014).

In 2014, more than half of mental health providers were not fully compliant with national quality standards for specialised hospital services and would require significant improvements (Calkin 2014b). Waits for, and within, specialist services have been identified as a particular problem, and evidence from surveys and audits suggests that access is insufficient and variable (Dormon 2015). Specialised commissioning of mental health beds across the country has been noted as a major concern (NHS Providers 2015b). A freeze in commissioning that was implemented during an NHS England review of provision had a particularly negative impact on the availability of services, exacerbating bed shortages (Lintern 2014).

- In 2013/14 NHS England overspent its budget for independent sector mental health providers by 55 per cent and £650,000 for NHS mental health providers. They predicted a further overspend in 2014/15.
- More than half of mental health providers commissioned by NHS England in 2014 to provide specialised care were not fully compliant with national quality standards and would require significant improvements.

## **Transformation of mental health services**

It is commonly assumed that a reduction in funding has resulted in mental health trusts running out of money. However, the finding that a substantial number of trusts continue to maintain a surplus contradicts this and suggests instead that mental health trusts have been taking action to reduce the costs of care. Our analysis of trust board papers and strategic plans demonstrates that for the majority of providers, the core action has been whole-system transformation of mental health services. Such transformation is strongly advocated in the NHS, however, the context and drivers that have influenced these programmes in mental health have resulted in mixed outcomes.

Few can dispute the intention and rationale for transformation programmes: simplifying service provision to facilitate access, integrating care, refocusing support downstream to intervene early and prevent relapse, and providing the environment and support for individuals to manage their own health. These changes reflect, and indeed in many cases pre-empt, the current impetus for transformation across the NHS. But in pursuing financial sustainability, mental health providers have arguably taken a leap in the dark in redesigning services, workforce and operations.

In seeking to achieve 'whole-system transformation' there has been a move away from the evidence-based models of care and treatments seen in previous programmes. Early waves of service redesign have resulted in the reduction of discrete specialist community services and more integration of these services into generic community mental health teams. It is acknowledged that the implementation guidelines for these services may have been excessively rigid and that insufficient attention was given to their integration as part of a whole service system (Gilbert *et al* 2014). However, the effectiveness of these services is dependent on the fidelity of the model – and changes to the model can impact on quality of care and outcomes. Clustering of care according to patient characteristics as part of the development of a national tariff payment system has also had a huge impact on services. In practice, many trusts have used this process to redesign the care pathways available for each of these groups. However, the evidence base for clustering is limited, while valid mechanisms for determining the service need, such as diagnosis and social, cultural and economic factors, have been given little or no consideration. This has resulted in a poor fit between the patients allocated to each cluster and the associated care available (Royal College of Psychiatrists 2014b). An analysis of plans submitted for review to the National Clinical Advisory Team concluded that in the majority of cases there was little evidence to support proposed transformation programmes in mental health (Imison *et al* 2014).

A number of current policy agendas, most commonly recovery, early intervention, integration and prevention, are cited as having a key influence on the direction of transformation programmes. Each has national policy support, however they have also been perceived as a means of shifting the demand of care towards less costly interventions. One of the key challenges is translating them into evidence-based practice. For example, recovery-orientated care reflects a change in the culture of care delivery, but interventions to support this cultural change at an organisational level have proved difficult to implement and demonstrate improved outcomes (Slade *et al* 2015). Furthermore, although individual programmes such as self-management and Individual Placement and Support can support recovery (Slade *et al* 2014), there is little evidence to inform whole-scale reconfiguration of services. Indeed, one of the sites implementing recovery through organisational changes was placed in special measures in 2015 following a significant deterioration in their financial position and an 'inadequate' rating of the trust by the Care Quality Commission (Monitor 2015; Care Quality Commission 2015b). Similarly, advocates of prevention have highlighted the importance of implementing and building on interventions that are proven to work (Davies 2013; Centre for Mental Health 2012). There is little question that there should be more recognition and support for the role that individuals play in managing their health and that a more diverse workforce can only benefit that endeavour. However, there is a big step from integrating individual interventions supportive of these agendas into care pathways and developing new care pathways, services and staffing which are defined by these agendas and for which there is little supportive evidence (Centre for Reviews and Dissemination 2011).

The scale and pace of change is particularly notable. Our own work on transformation highlights the time and investment required in large-scale transformation programmes (The King's Fund and The Health Foundation 2015). This includes a process of developing plans in collaboration with staff and service users, piloting service developments and importantly evaluating this before rolling it out across systems. The need to engage the workforce and to develop capacity and skills, access appropriate change management and evaluative expertise, and to double-run funding for new and existing services are all key to successful transition. Through their challenges in implementing recovery-orientated practice at scale, Leamy *et al* (2014) conclude that only organisations and teams that can demonstrate organisational readiness are likely to translate interventions effectively into practice. There is widespread investment in organisational transformation programmes across mental health trusts. Within the five-year timeframe that strategic plans cover, many trusts outline a full reconfiguration of services, workforce and corporate infrastructure. However, many plans allow minimal room for development, testing and evaluation – and most are undertaken with little or no additional external investment, precluding the support required for effective implementation. Although plans commonly refer to the risks associated with poor implementation, few factor in the risk that the plan itself may not deliver, or may have unforeseen consequences that will have a negative impact on the desired outcomes.

The transformation plans of providers have undeniably delivered on financial sustainability in the short term and, unlike acute sector trusts, there are fewer examples of mental health trusts going into deficit. But while the restructuring of services and workforce redesign may have achieved financial gains in some areas, in many cases it has failed to

address the underlying issues, has contributed to greater pressures in the mental health system through a reduction in access to evidence-based intervention, and has contributed to issues around quality of care and outcomes in mental health. The new care pathways may work for some people, but not everyone. A number of providers are reporting increased pressure on services from people with high needs while research suggests that others may have been 'squeezed out' (Green and Griffiths 2014). The authors suggest that people may no longer be receiving the support they require. Many of the wider services integral to planned shifts in demand from secondary mental health services such as primary care, social services and the voluntary sector are themselves limited in workforce capacity and are experiencing reductions in funding, which reduce their ability to support people in the community.

Activities associated with transformation programmes have undoubtedly resulted in a number of innovative service models and the emergence of a wider range of staff roles. However, a switch from nationally defined plans to local provider-driven transformation programmes is likely to have contributed to the high levels of variation reported in mental health (Care Quality Commission 2015c; Dormon 2015; The Commission on Acute Adult Psychiatric Care 2015; The NHS Benchmarking Network 2014; Naylor and Bell 2010), reducing the standardisation of mental health care and what service users and carers can expect from services in different parts of the country. In its evaluation of crisis care the Care Quality Commission (2015c) described finding 'variation in every direction' where an individual's experience of care was dependent on where they live and when they sought help. Limited standardisation of services and the absence of robust evaluations of new services and care pathways has limited the ability to identify which activities have improved outcomes and are cost-effective and, importantly, which have both compromised care and provided little financial gain. This situation is compounded by a lack of publicly available data. Successive investigations into quality have drawn attention to the paucity of useful national information on mental health services (Care Quality Commission 2015c; Dormon 2015; The Commission on Acute Adult Psychiatric Care 2015; QualityWatch 2014). In many areas of care there is no information at all, in others information is incomplete, of poor quality or unlikely to be representative of the true picture. Clinically reported outcomes were implemented in secondary mental health services in 2014, yet there is not enough reliable data to draw conclusions (Dorman 2015), while the survey on investment in mental health services was decommissioned in 2012. The NHS England Benchmarking programme was intended to facilitate the collection of funding, activity and outcomes data from mental health trusts to support quality improvement. This data may be valuable in helping to identify good practice where it is associated with a clear understanding of what good looks like and patient outcomes, and in holding providers and commissioners to account for changes being made.

The actions that mental health providers have taken in order to ensure financial sustainability have received little attention. A number of mental health trusts initiated transformation programmes before the first budget cut in 2010/11 on the expectation that their funding would be reduced. This lack of confidence is not unfounded; mental health services have traditionally been underfunded in comparison to physical health services, and there are a number of examples of mental health losing out to other sectors when funding is limited. As the former NHS London Strategic Health Authority noted following

the transfer of research funding from mental health to the cancer programme 'improving cancer services is one of our highest priorities, but spending more on all areas just isn't possible' (Clover 2012).

A final important factor is that mental health providers have few avenues to increase income or protect against increased financial pressures. The use of block contracts not only plays a key role in the impetus to control demand, but the contracting of multiple services through a single contract actively creates a mechanism by which reconfiguration can be undertaken across the system and at scale. The value of block contracts has not matched demand, which has forced providers to transform provision as they can no longer deliver the same service for the same price. The competing demands across the system and the limited expertise in commissioning mental health may have led some commissioners to be overambitious about the degree to which mental health transformation programmes could deliver savings and high-quality care, and limited their ability to identify the systemic impact of the changes being made.

## **Conclusion**

The relationship between funding in mental health and quality of care is not a simple one. Contrary to popular belief, the majority of mental health trusts have not run out of money. However, reductions in funding for secondary mental health services and a justified lack of confidence in future funding have triggered mental health trusts into transforming their organisations, services, staff and care in a process of whole-scale reconfiguration and redesign. These transformation programmes have delivered financial stability in the short term but it has failed to address ongoing issues with capacity and resulted in reduced access to the quality services and care that are demonstrated to improve the outcomes and lives of people with mental health problems.

Although many transformation plans have reduced the number of inpatient beds, their focus has predominately been on community-based mental health services. The Crisis Care Concordat steering group set up to support the improvement of crisis care warned of an NHS 'system failure' due to inadequate community-based mental health services (Siddique 2015). Despite a rise of 5.1 per cent in the number of people in contact with secondary mental health services, the number of contacts that people have with mental health services is falling with a reduction of 4.3 per cent in 2012/13 compared to the previous year (Health and Social Care Information Centre 2014) and further reduction of 3.1 per cent in 2014/15 (Health and Social Care Information Centre 2015b). They are also less likely to see a mental health professional, with only 52 per cent of service users surveyed in 2014 reporting having seen a mental health professional in the previous month, compared to 59 per cent in 2011 (Dormon 2015). A reduction in the proportion of people being supported under the Care Programme Approach indicates that they are also less likely to receive formalised support to plan and co-ordinate their care. Reductions in staffing and changes in skill mix have limited the ability to deliver timely and effective evidence-based care.

These transformation programmes are distinct from previous ones in being largely local and provider driven. While policy-makers have been strong advocates for improvement, the resources available nationally to actively support and oversee this process of

transformation have been minimal. The lack of publicly available data of sufficient quality and limited evaluation of the changes makes it difficult to identify the impact that the changes have had, hold providers to account and support improved commissioning.

Money is not the only solution to the issues highlighted in this briefing. However, having a level of funding that ensures financial stability and confidence in the mental health sector is key to creating a platform from which variation in quality and outcomes can be tackled. As the financial health of mental health trusts deteriorates, strategic plans show that several mental health trusts are starting to plan a new round of transformative changes. Without the capacity to stabilise change and learn from existing programmes of transformation, the infrastructure of mental health is at risk of being further reconfigured in a bid to remain financially viable.

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**November 2015**

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