



# 46: **The NHS Mandate** and its implications for mental health

## Introduction

The first NHS Mandate was published in November 2012 (Department of Health, 2012). It sets the Government's priorities for the NHS Commissioning Board between 2013 and 2015. The Board, which has national responsibility for spending the NHS budget, will be held accountable to the Department of Health for achieving the objectives in the Mandate.

The Mandate includes a number of important objectives to improve the support offered to people facing or living with mental ill health. This briefing paper examines the implications of each section of the Mandate for mental health. It identifies where mental health services are required to improve and where better mental health support could contribute to improvements in the performance of the NHS as a whole.



## Priority areas

The Mandate identifies five ‘priority areas’ for the Government ‘where it is expecting particular progress to be made’ (p6). They include:

“(ii) the diagnosis, treatment and care of people with dementia; (iii) supporting people with multiple long-term physical and mental health conditions...delivering a service that values mental and physical health equally; (iv) preventing premature deaths from the biggest killers; (v) furthering economic growth, including supporting people with health conditions to remain in or find work.”

Improvements in support for mental health are fundamental to the achievement of these priority areas. About one-third of people with a long-term physical illness have a co-occurring mental health condition. People with poor mental health have higher mortality rates from major illnesses such as heart disease and cancer. Dementia increases the risk and duration of hospital admissions. And people with mental health conditions also face high levels of sickness absence and unemployment. By taking mental health seriously across the NHS, not just in mental health services, the Board and clinical commissioning groups can achieve significant improvements in the quality, productivity and effectiveness of the services they commission.

## 1. Preventing people from dying prematurely

The first five areas of the Mandate mirror the five domains of the NHS Outcomes Framework. The NHS Outcomes Framework is a set of indicators of the performance of the NHS, divided into five ‘domains’ that aim to measure how well health services prevent premature mortality, enhance the quality of life of people with long-term conditions, help people to recover from illness or injury, provide a positive experience of care and offer safe care and avoid harm. The Mandate sets out how far the Government expects the NHS to have improved performance in each of these domains by 2015.

### Integrating physical and mental health

Preventing premature mortality is the first domain. A focus on mental health is vital both to addressing the high mortality rate of people with severe and enduring mental illness and to improving the life expectancy of people with co-occurring long-term physical and mental ill health.

The ‘improvement areas’ given for this domain include reducing ‘excess under 75 mortality in adults with severe mental illness’. Life expectancy among this group is now 15-20 years shorter than average in England (Chang *et al.*, 2011). The Schizophrenia Commission (2012) made a number of recommendations to address the excess mortality among this group, including the provision of targeted smoking cessation support for people with psychosis.

Other improvement areas in the Mandate include reductions in under-75 mortality from cardiovascular disease, respiratory disease, liver disease and cancer.

There is now clear evidence that poor mental health is a factor in increasing both morbidity and mortality from these conditions. Ensuring that people with major physical illnesses are given support for their mental health should contribute to reducing mortality rates.

Collaborative care arrangements for people with co-morbid long-term physical conditions and depression are recommended by NICE (2009). By integrating mental and physical health support in primary care, including the provision of case management, psychological therapy and medications review, collaborative care arrangements can improve quality while reducing cost (Naylor *et al.*, 2012).

Liaison psychiatry services within general hospitals can also contribute substantially to improving the care people with mental health conditions receive when they are in hospital. An analysis by the Centre estimated that a liaison psychiatry team could save a 'typical' general hospital £5 million a year in reduced bed days among older patients (Parsonage *et al.*, 2012). It is also vital that the Improving Access to Psychological Therapies (IAPT) programme successfully extends to people with long-term physical conditions. This aspect of the programme is currently at a pilot stage.

### **Treatment recommended by NICE**

This section of the Mandate also sets the NHS Commissioning Board the objective of:

“...ensuring people have access to the right treatment when they need it, including drugs and treatments recommended by the National Institute for Health and Care Excellence, and services for children and adults with mental health problems” (p7).

Guidance from NICE for a range of mental health conditions continues to be followed patchily in practice. Guidelines and Quality Standards relating to mental health should be given equal precedence to technology appraisals in order to achieve best value for money.

### **The NHS workforce**

The Mandate notes that, “as the country’s largest employer, the NHS should also make a contribution by promoting the mental and physical health and wellbeing of its own workforce.” (p8)

The independent review of health among the NHS workforce, led by Dr Steve Boorman (2009) set a clear agenda for improving NHS employers’ support for the health and wellbeing of their staff. NHS organisations can lead by example, providing staff with good mental health support when it is required and ensuring that their recruitment processes encourage people with mental health problems to apply for work. Commissioners can extend this leadership to their contracting processes, encouraging independent sector providers to take a similarly positive approach to employing people with mental health problems.

## 2. Enhancing quality of life for people with long-term conditions

The second domain of the NHS Outcomes Framework focuses on the quality of care offered to the one person in three at any time who has one or more long-term physical or mental health condition. It states that:

“The NHS Commissioning Board’s objective is to ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment.” (p9)

### Personalisation and Recovery

Specifically, it states that: “by 2015...everyone with long-term conditions, including people with mental health problems, will have a personalised care plan that reflects their preferences and agreed decisions.” It adds that, by the same year, “patients who could benefit will have the option to hold their own personal health budget, subject to the evaluation of the pilot programme” (p10).

Mental health services are focusing increasingly on support that enables people to achieve personal Recovery. Recovery in mental health care is about enabling people to lead the best lives they can, on their own terms, with or without the symptoms of mental illness. It is a very different approach to mental health care from the traditional focus on clinical recovery and symptom management: placing the emphasis of care planning on what will help the individual to get on with their life rather than postponing social and personal goals while they are experiencing the symptoms of illness (Shepherd *et al.*, 2008).

The use of personal budgets and improved care planning should help mental health services to become more recovery-oriented (Alakeson & Perkins, 2012), together with other changes to mental health practice and service provision.

A pilot project in Northamptonshire provided 19 people with personal health budgets of between £1,800 and £29,000, of which 62% was spent on ‘traditional’ mental health services and 38% on other services such as personal assistants, education and exercise (MHSP, 2012).

Centre for Mental Health and the NHS Confederation Mental Health Network have come together to develop the Implementing Recovery through Organisational Change (ImROC) project to support mental health services to become more Recovery-oriented. The project offers mental health service providers with expert advice and peer support to implement organisational changes that will help them to promote Recovery in all aspects of their work.

For more information about Recovery, visit [www.centreformentalhealth.org.uk/recovery](http://www.centreformentalhealth.org.uk/recovery).

### Employment

Measures from the NHS Outcomes Framework towards this domain include ‘employment of people with mental illness’ as well as generic measures that include people with mental health conditions among others, such as ‘health-related quality of life’ and the ‘proportion of people feeling supported to manage their condition’.

Employment rates among people who use mental health services remain low, at about 12%, and well below the proportion who would like to try paid work. Successive Care Quality Commission patient surveys have found that only about half of service users who would like help to get or keep work actually receive it (CQC, 2012).

There is, nonetheless, clear evidence of how to support people using mental health services to gain and retain paid work. The Individual Placement and Support (IPS) approach can achieve employment rates of 50-60% if it is implemented faithfully (Sainsbury Centre for

Mental Health, 2007). A growing minority of NHS mental health trusts now operate an IPS service, including for young people experiencing a first episode of psychosis.

In Sussex, Southdown Supported Employment and Sussex Partnership NHS Foundation Trust significantly improved employment rates among service users through increased use of IPS with the support of a 'regional trainer' to boost staff skills and confidence in implementing this approach (Centre for Mental Health, 2012).

For more information about Individual Placement and Support visit [www.centreformentalhealth.org.uk/employment](http://www.centreformentalhealth.org.uk/employment).

### 3. Helping people to recover from episodes of ill health or following injury

The third section of the Mandate focuses on how the NHS supports people to 'get back as quickly or as much as possible to their everyday lives' (p13) in partnership with 'patients, families and carers, social services and other agencies'.

#### 'Parity of esteem'

The Mandate notes that 'there are huge and unwarranted differences in quality and results between services across the country'. Its objective for the Board is:

"...to shine a light on variation and unacceptable practice, to inspire and help people learn from the best." (p13)

Differences in the treatment of mental and physical health are among the disparities the Mandate highlights. It states that:

"By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence-based services. This will involve extending and ensuring more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people, and for those out of work." (p14)

Specifically, the objective for the Board is to ensure that 'at least 15% of adults with relevant disorders will have timely access to services, with a recovery rate of 50%'.

The Commissioning Board has announced that it will continue to support the IAPT programme from April 2013. It is vital that Clinical Commissioning Groups ensure that IAPT services continue to develop and diversify in their localities. Developing IAPT services should not lead to a diminution in existing, clinically effective, psychological therapy services.

## 4. Ensuring that people have a positive experience of care

The fourth section focuses on the quality of people's experiences of NHS care.

The first objective for the Board is to address the support offered to 'vulnerable people, particularly those with learning disabilities and autism' following the abuses that were exposed at Winterbourne View hospital (p16). Subsequent to the publication of the Mandate, the Department of Health produced guidance on the changes it expects to see in provision for this group, including a shift from inpatient care to improved community provision.

### Maternity services and parenting

The Mandate also sets out an objective for the Board:

"...to improve the standards of care and experience for women and families during pregnancy and in the early years for their children." (p17)

Within this objective it sets specific goals including: action to 'reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support' (p18); using the increased health visitor workforce to improve safeguarding arrangements for vulnerable children; and improving support for children with special educational needs and disabilities.

There is now persuasive evidence of the health and financial benefits of intervening early to address mental health issues early in childhood. Perinatal mental health problems are major risk factors for poor mental health in children. NICE guidance (2007) suggests that all areas have in place a range of perinatal mental health services to identify and support women experiencing mental ill health during and after pregnancy.

Parenting interventions for families whose children have early behavioural problems or a high risk of conduct disorder are highly

cost-effective. Implementation of parenting programmes has been patchy, but provision of evidence-based interventions such as Family Nurse Partnerships and training schemes such as Incredible Years and Triple P is growing. Three-quarters of parents whose children have serious behavioural problems seek help, often from their GPs. It is crucial that primary care services are aware of the significance of behavioural problems on a child's health and life chances are know how to refer parents to evidence-based programmes (Brown *et al.*, 2012).

### Access to services

A further objective for the Board is to uphold the rights and commitments of the NHS Constitution to timely access to treatments. The Mandate acknowledges that in mental health care these rights are under-developed and lag behind those for other areas of health care. It states that:

"As part of its objective to put mental health on a par with physical health, we expect the Board to be able to comprehensively identify levels of access to, and waiting times for, mental health services. We want the Board to work with CCGs to address unacceptable delays and significantly improve access and waiting times for all mental health services, including IAPT. We will also work with the Board to consider new access standards, including waiting times, for mental health services, including the financial implications of any such standards." (p18-19)

Delays in treatment for mental health problems can be costly. Three-quarters of people with depression never receive any treatment or support. The consequences of untreated depression can include job loss, disrupted education and poorer physical health and life expectancy. Early and prompt intervention is vital in almost all mental health conditions, including behavioural problems in childhood and emerging psychosis among young people (Brown *et al.*, 2012; Birchwood *et al.*, 1998).

Evidence from the United States in particular indicates that Early Intervention in Psychosis services are key to improving outcomes, including in education and employment (Frank, 2013)

Improving waiting times for mental health care requires action on several fronts. Access and waiting times for evidence-based psychological therapies are a crucial litmus test of ‘parity of esteem’ between mental and physical health. Access to community services and CAMHS is also crucial.

In an emergency, immediate access to effective crisis services is vital, including the provision of appropriate Places of Safety for adults and children detained by the police under sections 135 and 136 of the Mental Health Act. Transfers from prison to hospital remain particularly problematic: a previously set target of 14 days has since lapsed and there are now wide variations in waiting times with multiple assessments (Durcan, 2011).

Efforts to improve waiting times for mental health care will require significant improvements in the measurement and monitoring of access to a range of services, emergency and routine, with safeguards to ensure that ‘gaming’ does not distort priorities or exclude some groups of people from services.

### **Patient experience**

Indicators from the NHS Outcomes Framework that support this domain include ‘patient experience of community mental health services’, derived from the Care Quality Commission’s survey of this group. It also includes the ‘Friends and Family Test’, which at present is not applied to mental health care. It does not, however, include measures of experience of psychiatric inpatient or secure services.

Improving the measurement of people’s experiences of all forms of mental health care is vital to better understand the outcomes they achieve. The keys to mental health Recovery

have been described as ‘hope, control and opportunity’. The degree to which services, and those who work in them, give users a sense of hope for the future and control over the care and support they receive needs to be gauged in order to understand how well they are performing if they are to achieve the objectives of the mental health strategy.

## 5. Treating and caring for people in a safe environment and protecting them from avoidable harm

The fifth section focuses on patient safety in the NHS. The Board's major objective in this domain is to 'embed a culture of patient safety in the NHS including through improved reporting of incidents' (p20). Within it, the Mandate notes that:

"The Board will need to work with clinical commissioning groups to ensure that providers of mental health services take all reasonable steps to reduce the number of suicides and incidents of serious self-harm or harm to others, including effective crisis response." (p20)

Suicide rates have been falling in England for the last decade, although there has been a small increase in the last two years (ONS, 2010). The Department of Health recently published a new suicide prevention strategy to focus efforts on the groups of people who face the highest risk (HM Government, 2012b).

Incidents of serious self-harm and suicide are a cause for particular concern in the justice system: including in police custody, in prison, among young offenders and in the weeks following release from custody. The NHS is taking on responsibility for health care provision in police custody in many areas of England. This should enable the Board and CCGs alike to identify ways of improving mental health support to offenders not just when they are in custody but at all stages of their journey through the justice system.

## 6. Freeing the NHS to innovate

Beyond the five Outcomes Framework domains, the Mandate sets the Board objectives relating to innovation in the NHS, the NHS's relationship with other local services, and the NHS's finances. These objectives focus on the ability of the health and care system to function effectively and efficiently.

Specific objectives for the Board with regard to innovation include by 2015 to have 'fully embedded all patients' legal rights to make choices about their care, and extend choice in areas where no legal right yet exists. This includes offering the choice of any qualified provider in community and mental health services' (p23). It also asks for 'significant improvements in extending the system of prices paid to providers, so that it is transparent, and rewards people for doing the right thing'.

The NHS Constitution currently gives patients the right to receive services approved by a NICE technology appraisal. Most mental health treatments, however, are assessed by NICE outside the technology appraisal process. This means that many psychological therapies and other highly cost-effective interventions are approved through NICE Guidelines and Quality Standards for which a legal entitlement does not currently exist.

The implementation of the 'any qualified provider' approach in mental health services could enable more people to make choices about the care and support they would like to receive. There is a risk, however, that small-scale community and voluntary sector initiatives, many of them user-led, will struggle to meet the criteria for being included in this scheme. For Black and minority ethnic communities in particular, access to alternatives to mainstream provision can be crucial.



## 7. The broader role of the NHS in society

With regard to partnership working, the Mandate requires the Board to demonstrate progress in a number of areas including:

- “contributing to multi-agency family support services for vulnerable and troubled families;
- upholding the Government’s obligations under the Armed Forces Covenant;
- helping people experiencing ill health, whether mental or physical, to remain in or return to work, and avoid homelessness;
- developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services;
- championing the Time to Change campaign to raise awareness of mental health issues and reduce stigma, including in the NHS workforce.” (p24-25)

Working in partnership with other local agencies is key to improving the support the NHS offers to people with mental health conditions. Health services alone cannot achieve the outcomes they aspire to without the cooperation and support of a range of agencies, including not just social services but criminal justice, employment, education and housing. The mental health strategy and implementation framework (HM Government, 2011; 2012a) set out clearly the priorities for a number of services to help to achieve its six objectives. Clinical commissioning groups, working alongside health and wellbeing boards, can offer strategic leadership, and lead by example, in forming, sustaining and giving priority to effective partnerships in their localities.

The development of liaison and diversion services for every police station and court in England is in progress and will be led by the Commissioning Board from April 2013. It will only be effective, however, if appropriate services are made available to both children

and adults who are identified as requiring support. Clinical commissioning groups will need to ensure in particular that community-based services such as CAMHS and assertive outreach are in place for those who need ongoing support. This is especially important for people who are given a community sentence including a Mental Health Treatment Requirement (Scott & Moffatt, 2012).

Local NHS commissioners will also need to develop services for people who are released from prison and for those who are discharged from secure mental health care. Long delays in discharging people from secure hospitals can result from the absence or paucity of community and step-down services for those who need more intensive support while they are adjusting to life in their community (Durcan, 2011).

For more information about mental health and criminal justice visit [www.centreformentalhealth.org.uk/criminal\\_justice](http://www.centreformentalhealth.org.uk/criminal_justice) or the National Liaison and Diversion Development Network [www.nliddn.org.uk](http://www.nliddn.org.uk).

## Conclusions

Improving support for people with mental health conditions features strongly throughout the NHS Mandate. This reflects the aim of achieving ‘parity of esteem’ between mental and physical health as well as the important contribution that improving mental health can make to our overall health and wellbeing. It also builds on the objectives of the mental health strategy and the commitments made in the implementation framework to make the vision a reality.

The Mandate does have significant gaps. The Commissioning Board’s specialist commissioning areas are poorly covered, particularly secure mental health care. At a cost of £1.2 billion, secure services are in urgent need of a new approach to commissioning to improve both efficiency and outcomes (Durcan, 2011). There is also scant mention of the importance of race equality in mental health care and of improving the experience of those who are detained under the Mental Health Act despite continuing evidence of variability in people’s experiences of compulsory care and growing use of the Act in recent years (CQC, 2013).

The Mandate also reflects continued weaknesses in outcomes and process measurement in mental health care. While the Mental Health Minimum Dataset provides increasingly reliable information about aspects of service use, routine data about waiting times, patient experience and Recovery is not yet collected. Information about the experiences of children and of older adults is especially sparse and in need of concerted action to fill the gaps.

The Mandate does, nonetheless, send a clear message to the NHS at all levels that mental health should be accorded equal prominence to physical health. It sets out clear priorities for both immediate action and further development in the commissioning of mental health care. It should enable clinical commissioning groups to focus on key improvement areas in their localities.

### Key actions for the NHS Commissioning Board

1. Continue and complete the IAPT programme, including for people with long-term conditions and those with severe mental illness.
2. Develop effective measures of access and waiting times for a range of mental health services.
3. Sustain the development of liaison and diversion services, linking with local commissioners to ensure support is available for people diverted to community services.
4. Work with Public Health England to improve access to effective parenting interventions, targeted at the families who need them most.
5. Encourage and support efforts to improve the life expectancy of people with a severe mental illness and those with coexisting mental and physical conditions.

### Key actions for clinical commissioning groups

1. Commission integrated support for people with co-existing physical and mental health conditions, including liaison psychiatry services in hospitals and collaborative care in the community.
2. Commission for early intervention, including ready access to psychological therapies and high quality Early Intervention in Psychosis services.
3. Commission for Recovery in mental health care, for example through the use of personal budgets.
4. Commission effective employment support to enable more people with mental health problems to gain and retain paid work.
5. Commission a range of effective crisis services that are available when they are needed, including places of safety, for people of all ages.

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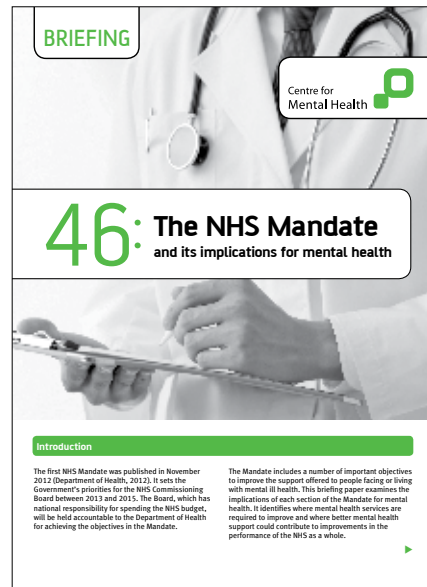
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