The Mental Health Policy Group

NHS Health and Care Bill – Bill Committee Submission

6 September 2021

Background

The Mental Health Policy Group (MHPG) comprises the Mental Health Foundation, Mind, Rethink Mental Illness, the Mental Health Network of the NHS Confederation, Centre for Mental Health and the Royal College of Psychiatrists. Together we represent providers, professionals, commissioners and hundreds of thousands of people who use mental health services and advocate for cross-government approaches to improve services and support early intervention and prevention of mental health problems.

We wish to relay our perspective on the legislation as, when implemented, it will mean significant changes for providers, mental health professionals and people with mental illness.

This position is endorsed by:

Centre for Mental Health
Mental Health Foundation
Mental Health Network of the NHS Confederation
Mind
Rethink Mental Illness
Royal College of Psychiatrists

The Royal College of Psychiatrists, Rethink Mental Illness, Mental Health Foundation, Centre for Mental Health and NHS Confederation are also sending separate evidence submissions to the Health and Care Bill Public Bill Committee.

Summary of our key recommendations:

- A new duty should be added for Integrated Care Boards (ICBs) to 'Promote parity of esteem between physical and mental health', and to demonstrate work toward this through forward planning and annual reports.
- Representation from an NHS trust with responsibility for mental health should be legally required on ICBs alongside other types of NHS trusts.
- Legislation must include a duty for ICBs and Integrated Care Partnerships (ICPs) to co-produce with people with lived experience, and to collaborate with voluntary, community and social enterprise organisations.
- There needs to be a clear legal requirement for NHS England and ICBs to identify health inequalities and commission services that are designed to reduce them. ICPs should also have a duty to address health inequalities.
- Responsibility for national and local leadership on public mental health needs to be clarified.

- Responsibility for social care needs to be clarified.
- The Secretary of State for Health and Social Care should, at least once every two years, independently verified workforce supply and demand projections.

Context

1) We believe that the proposals set out in the Bill have the potential to significantly improve the care provided to people with mental ill health. The focus on partnership and integration could lead to better coordinated and more effective care, and stronger local relationships between health and care partners to support this. Integrated care systems' (ICS) partners can learn from the mental health care system due to its experience in developing and embedding integrated approaches to service delivery, joint commissioning, co-production, and working closely with the voluntary sector and local government.

2) There is, however, a danger that the voice of mental health providers and patients will be drowned out unless there are clear legal duties to work towards parity of esteem. Despite a national commitment to parity of esteem for mental health, to which the previous Secretary of State for Health and Social Care recently reaffirmed his commitment[i], patients with a mental illness can find it hard to access the support they need[ii]. We also have concerns about the voice of mental health trusts in ICS governance structures, in which they must have an adequate stake in decision-making[iii].

3) Mental health problems are one of the most significant causes of disability in England, affecting one in five mothers during pregnancy or in the first year after childbirth, one in eight children and young people, and one in six adults[iv]. Our mental health can be deeply affected by the social determinants of health and our environment[v]. A population health-based approach is core to ICS planning and decision making, and mental health is a key population need across the country. The triple aim of ICSs is to improve care for patients, improve population health and wellbeing and make the most efficient use of NHS resources. This will not be achieved without mental health being at the centre of ICSs.

4) Given the prevalence of mental illness, we should be working towards parity of esteem for mental and physical health at every opportunity. As a group of mental health-focused organisations, we have directed much of our work toward supporting and advocating for the timely implementation of the NHS Long Term Plan, and specifically the Mental Health Implementation Plan. We have also been strongly advocating for a whole-government approach to mental health, which recognises and addresses the social and economic determinants of mental health.

5) We are viewing the Bill through the framework of this plan and in the context of this ambition for integrated action on preventing and responding to mental health problems earlier. We urge the government and parliamentarians to give strong consideration as to how the reforms will help the system deliver these commitments, and also the need for greater integration in relation to public mental health.

6) We know that in order to support the mental health of our society, a collaborative and personalised approach is needed for every individual. People with mental ill health often have other comorbidities, and use a range of services across the system, including primary and secondary care, urgent and emergency care and social care in both a physical and mental health context. Unfortunately, people often report poor coordination of care and gaps in services[vi]. We have heard from many clinicians and service users working in and accessing mental health services within ICS oversight, and they are developing and benefitting from innovative new models of care[vii] [viii]. However, we must ensure mental health is given equal focus through the newly proposed models, and so we recommend the following:

Recommendations*:*

7) A new duty should be added for ICBs to 'Promote parity of esteem between physical and mental health', and to demonstrate work toward this through forward planning and annual reports.

8) Every ICB should be required to promote parity of esteem. It should be included in their 'forward plans' and they should be required to report on it as part of their annual reports. This would increase transparency and help hold the system to account.

9)This should not create extra burdens or be a box ticking exercise because NHS England and NHS Improvement already require annual information on how local areas are progressing against national plans to improve care for people with a mental illness, including information on waiting times and patient outcomes. Implementing our recommendation would largely involve making this information public within the ICB annual report.

10) Proposed amendment:
Part 1, page 18, line 25 insert new clause:

- Duty to promote parity of esteem between mental and physical health.

  Each integrated care board must have regard to, in the exercise of its functions, the equal importance of mental and physical health.

11) Proposed amendment:
Clause 14Z50, page 21, line 12, at end insert:

- Section [insert new clause on duty to promote parity of esteem between mental and physical health] Duty to promote parity of esteem between mental and physical health.

12) Member's explanatory statement
This amendment would require the joint forward plans for integrated care boards and their partners to include a description of how they plan to meet their duty to promote parity of esteem between mental and physical health.

13)Proposed amendment:
Clause 14Z56, page 24, line 30, at end insert:

- Section [insert new clause on duty to promote parity of esteem between mental and physical health] Duty to promote parity of esteem between mental and physical health.

14) Member's explanatory statement
This amendment would require the integrated care board annual reports to include a review of what they have done to meet their duty to promote parity of esteem between mental and physical health

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15) Representation from an NHS trust with responsibility for mental health should be legally required on the ICB, alongside other types of NHS trusts.

16) Currently, the legislation states that the minimum requirement for 'ordinary members' on the ICB is one local (unspecified) trust, one primary care representative and one local authority representative. Mental health representation on the ICB is critical not only for parity of esteem (which the government has committed to) but also for a comprehensive population health-based approach. Funding decisions, including allocation of resources to mental health and the Mental Health Investment Standard, will also be made at the ICB level.

17) How the representation is arranged can be determined locally, with areas with more than one mental health trust agreeing on a representative on behalf of others. For areas where one trust provides both mental health and acute services, it would also be acceptable for that trust to represent the mental health perspective.

18) While we understand there is appetite from ICSs to include mental health representation on ICBs, this is not mandated in the legislation, and it was also not made clear in the *interim guidance on the functions and governance of the integrated care board* that mental health representation is required by NHS England. If it is unlikely that unitary boards will exclude mental health representatives in reality, then we strongly urge it to be an explicit requirement from the outset.

19) Proposed amendment:
Schedule 2, Page 120 line 14 leave out subsection (a) and insert:

- "(a) one member nominated jointly by the NHS trusts and NHS foundation trusts that—
  provide services for the purposes of physical healthcare within the integrated care board's area, and
  are of a prescribed description;
  (b) one member nominated jointly by the NHS trusts and NHS foundation trusts that—
  provide services for the purposes of mental healthcare within the integrated care board's area, and
  are of a prescribed description;"

20) Member's explanatory statement
This amendment would require Integrated Care Boards to have members representing trusts whose primary responsibility is for mental health care as well as trusts whose primary responsibility is for physical healthcare.

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21) Legislation must include a duty for ICBs to co-produce with people with lived experience, and to collaborate with the voluntary sector and community organisations as they carry out their functions at system, place and neighbourhood level. Collaborative efforts must represent the diversity of the local population in planning and decision making, and proactively address discrimination.

22) People with lived experience and the VCSE sector must also be included within the ICP. Without this there is a very high risk that we will simply entrench existing inequalities and fail to address the needs of underserved groups.

23) The legislation in its current form includes a duty on ICBs to *"involve individuals to whom services are being provided or may be provided"*. However, systems must go further than simply consulting or providing information to patients. Co-production is the active inclusion of people with lived experience in the design, delivery and evaluation of services. It has been shown to provide considerable benefits to services and patients and therefore a duty for both ICB and ICPs to co-produce with people with lived experience would help ensure services work for the populations they serve.

24) VCSE organisations and their workforce play a vital role in supporting people with a mental illness, and they will be key players in helping the system address the increase in demand for mental health support. They also bring a wealth of expertise and insight about the needs of their local population, including groups underserved by statutory services.

25) We welcome the instruction from the ICS Design Framework for ICSs to develop formal arrangements to work with the VCSE sector, but due to the importance of this sector, we feel that the legislation should be stronger in this area and include a legal duty for ICBs and ICPs to work with VCSE organisations.

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26) Responsibility for national and local leadership on public mental health needs to be clarified. As we recover from the pandemic, it is more important than ever that we redouble our efforts to protect the public's mental health. This must include taking early action to address the factors that can lead to it deteriorating.

27) Furthermore, the measures on public health in this Bill will only be effective if the Government's reform of central public health responsibilities (following the dissolution of Public Health England) creates an environment where public health is a national priority. We need to see a new strategy on public mental health, backed with investment, that seeks to tackle the inequalities that have been deepened by the pandemic.

28) It is not yet clear whether public mental health will be situated within the new Office for Health Improvement and Disparities. We recommend that this is the case, so that the drive to give mental health parity with physical health can be sustained in this new Office. The Government should clarify that this is its intention.

29) There are a number of areas where the Bill's provisions could be expanded upon to ensure that public mental health is embedded in the new system. These are set out in full in the Mental Health Foundation's evidence to the Committee. Specific amendments that are needed to improve the delivery of public mental health initiatives are set out below.

30) Duty to follow ICP strategy

The Bill should be amended to strengthen the requirement for Integrated Care Boards (ICBs) to follow the Integrated Care Partnership (ICP) strategy, rather than just 'having regard to' it, avoiding the risk that they become under-used advisory documents, without practical relevance.

31) Proposed amendment:

Replace Part 1, Clause 20 (6) with:

(6) For section 116B substitute—

"116B Duty to have regard to **and fulfil** assessments and strategies

(1) A responsible local authority and each of its partner integrated care boards must, in exercising any functions, have regard to the following so far as relevant —
(a) any assessment of relevant needs prepared under section 116 in relation to the responsible local authority's area and,
(b) any joint local health and wellbeing strategy prepared under section 116A by the responsible local authority and its partner integrated care boards.

(2) A responsible local authority and each of its partner integrated care boards must, in exercising any functions, **fulfil requirements of them specified** in any integrated care strategy prepared under section 116ZB in relation to an area that coincides with or includes the whole or part of the responsible local authority's area.

The substantive change in the above amendment is marked in bold for clarity.

32) Advice on health improvement and prevention

The Bill currently requires ICBs to obtain advice on health improvement and prevention of illness, but it does not make clear that this includes mental health. The Bill should be amended to ensure that ICBs always obtain advice holistically on health improvement and prevention, making it clear that this includes *mental*, and not just physical, health.

33) Proposed amendment:
Replace 14Z38 under Part 1, Clause 19 with:

- **14Z38 Duty to obtain appropriate advice**
  Each integrated care board must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in —

  (a) the prevention, diagnosis or treatment of physical **and mental** illness, and

  (b) the protection **and** improvement of public health**, including public mental health**.

Changes to the existing clause are shown in bold for clarity.

34) Inclusion of public health representatives in Integrated Care Partnerships

The Bill should be amended so that it reflects the Government's stated aim to ensure that public health is represented in Integrated Care Partnerships. This is made explicit in the Bill's explanatory notes, but does not appear in the Bill itself.[1]

35) Proposed amendment:
In Part 1, Clause 20 (4) after line 7 insert:

- 'one member appointed by the integrated care partnership with local responsibility for public health delivery'.

36) Member's explanatory statement

These amendments will ensure that public mental health and prevention is embedded in the new system.

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37) Responsibility for social care needs to be clarified. We would highlight similar concerns to those we have indicated on public health. We welcome reassertions of the intention to bring forward plans to reform social care from the Secretary of State within the recent second reading debate on this Bill, but without detail on planning and confirmed funding for social care, it is difficult to understand what these reforms will mean for mental health.

38) We are concerned that the government's current thinking around social care reform focusses too much on older adults, even though over half the social care budget is spent on working-age-adults. Children's social care is also facing significant funding pressures; in particular, early intervention and preventive work has been reduced in many areas.[ix] Mental health is also all-too-often absent from the conversation, despite representing around 1 in every £11 of gross social care expenditure. Social care support for people with a mental illness is critical to the implementation of the Community Mental Health Framework, and for prevention of admissions to expensive inpatient services. It facilitates discharge to free up

[1] Set out on page 17 of the explanatory notes.

beds to those that need them, and plays a vital role in supporting local authorities to meet statutory duties under the Mental Health Act, Care Act and Mental Capacity Act.

39) Furthering integration between health and social care is undoubtedly a positive ambition for this legislation, but without the necessary detail it is difficult to understand what these reforms mean for mental health.

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40) There needs to be clearer legal requirements for NHS England and ICBs to commission services that are designed to reduce health inequalities, including an additional requirement for ICBs to assess and reduce health inequalities, and a duty introduced for ICPs to address them.

41) One of the core objectives of an ICS is to reduce health inequalities in its local area. This should include mental health inequalities specifically, for which substantial inequalities persist, including racial inequalities. ICSs should also be able to demonstrate actions to prevent disparities in rates of illness in the population through preventive interventions for groups that are at high risk, and to facilitate recovery and rehabilitation.

42) This should include groups of individuals with protected characteristics and clinical need but should also go beyond these specific characteristics to ensure that all inequalities are addressed, including socioeconomic status, and groups too often ignored in public policy, such as those with refugee and asylum status.

43) The Advancing Mental Health Inequalities Tool[x] and the Patient and Carer Race Equality Framework[xi] should be used at the commissioner and provider level when planning and delivering services.

44) We welcome the duties within the Bill on ICBs to reduce health inequalities and to report annually on this. We believe this should be strengthened by including a specific duty to identify inequalities in health, in access to care and in outcomes, and to take steps to address them within their annual plans and five-year strategies.

45) There also needs to be clarity on how ICSs will be accountable for the responsibility to reduce health inequalities, how progress will be measured, and which groups will be included when assessing health inequalities. NHS England guidance states that the ICP's 'integrated care strategy' must address health inequalities; however, we believe this could be strengthened by including a duty on ICPs in the legislation to address health inequalities. There may also be a role for the Care Quality Commission in holding ICSs to account for how far and how well they address health inequalities in their local areas.

46) Proposed amendment:
Section 13NA and Section 14Z43 require NHS England and integrated care boards respectively to have regard to the wider effects of their decisions. We would suggest the following amendment:

- Part 1, Page 18, after line 13 insert:

(d) reducing inequalities in mental and physical health and wellbeing between different groups of people within the population.

47) Proposed amendment:
At present, Section 14Z35 of the Bill specifies that integrated care boards should take steps to reduce inequalities in *access to* health services and in *outcomes from* them. It also does not address the importance of improving the social determinants of health and the role this will play in reducing health inequalities. We would suggest the following amendment:

- Part 1, Page 16, after line 28 insert:

(c) assess and reduce inequalities in health between different groups of people within the population of its area.
(d) address inequalities by improving the social determinants of health by (i) require organisations to pay employees and contractors the real living wage. (ii) using social value procurement principles to support local employment, training and apprenticeships, especially of those who may struggle to gain opportunities including those with serious mental illness, common mental health disorders, learning disabilities and those leaving care and prison.

48) Member's explanatory statement
These amendments would strengthen the duty and accountability of ICBs to reduce health inequalities.

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49) The Secretary of State for Health and Social Care should, at least once every two years, report independently verified workforce supply and demand projections.

50) Mental health is one of the areas of the NHS which has suffered most because of a lack of clear workforce planning. This means that, recruiting enough skilled staff to meet the needs of patients is an urgent challenge.

51) For example, in the plan to deliver the Five Year Forward View for Mental Health (*Stepping forward to 2020/21: the mental health workforce plan for England*), the Government set a target to employ 570 more consultant psychiatrists and 8,100 mental health nurses by March 2021. This deadline has now passed and there has been a failure to expand the mental health workforce. By March 2021, the NHS only filled 210 out of the target 570 (37%) consultant psychiatrist posts and 3,010 of the target 8,100 (37%) mental health nurses[xii].

52) Furthermore, the NHS Long Term Plan is meant to build on the planned workforce set out in the Five Year Forward View, yet as of March 2021 we were around 420 consultant psychiatrists behind the target for 2020/21, and therefore on course to miss the LTP target by 2023/24[xiii].

53) In part, this is because workforce planning has come too late in the planning cycle. For example, the workforce plan for the Five Year Forward View for Mental Health was published

over a year later. It is also due to short-term workforce planning that fails to understand the length of time it takes to train staff, which is evidenced by two one-year People Plans that do not align with the workforce targets required to implement the Long Term Plan. To-date, there has also been no transparent attempts to sufficiently compare workforce supply against workforce demand meaning that persistent workforce shortages remain a reality.

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

55) The current provisions in the Bill provide no clarity as to whether the system is training and retaining enough people to deliver services both now and in the future. To ensure that we have the staff numbers required to deliver the work that the Office of Budge Responsibility estimates we will need to carry out in future, we recommend the biannual publication of a report that sets out:

- workforce numbers at the time of publication and projected supply for the following 5, 10 and 20 years;
- future workforce numbers based on the projected health and care needs of the population for the following 5, 10 and 20 years.

56) While this will not solve the workforce crisis, it will give us the best foundations to take long-term decisions about workforce planning to keep up with population need. It should, therefore, be used to inform ICS and regional training and recruitment needs, as well as underpin national recruitment and retention strategies. While the proposed amendments below do not specifically include the VCSE workforce, we would strongly advise that this vital part of the workforce are included when national, regional and ICS workforce plans are developed.

57) Proposed amendment:

Part 1, Page 40, line 4, After section 1G of the National Health Service Act 2006 (but before the italic heading after it) insert:

- 1GA Secretary of State's duty to report on workforce systems

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

  (2) This report must include:
  (a) an independently verified assessment of health, social care and public health workforce numbers, current at the time of report publication and the projected supply for the following 5, 10 and 20 years.
  (b) an independently verified assessment of future health, social care and public health workforce numbers based on the projected health and care

needs of the population for the following 5, 10 and 20 years, consistent with the Office for Budget Responsibility long-term fiscal projections.

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

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

58) Member's explanatory statement

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

For further information please contact Emma Paveley, Senior Policy Manager, Mental Health Network and Chair of the Mental Health Policy Group; Emma.Paveley@NHSconfed.org

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[iii] Royal College of Psychiatrists. 2019. *Improving mental health services in systems of integrated and accountable care: emerging lessons and priorities.* Accessed at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych---improving-mental-health-services-in-systems-of-integrated-and-accountable-care-final.pdf

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

[vi] Care Quality Commission. 2020. *Community mental health survey 2020.* Accessed at: https://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2020

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[ix] House of Commons Library (2021). Children's social care services in England. Accessed at: https://researchbriefings.files.parliament.uk/documents/CBP-8543/CBP-8543.pdf

[x] Royal College of Psychiatrists. 2019. *Advancing Mental Health Equality.* Accessed at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/amhe/amhe-resource.pdf

[xi] NHS England. Undated. *Advancing mental health equalities.* Accessed at: https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/

[xii] NHS Digital. 2021. *NHS Workforce Statistics - March 2021*. Accessed at: NHS Workforce Statistics - March 2021 (Including selected provisional statistics for April 2021) - NHS Digital

[xiii] Ibid.