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Mental healthcare is a crucial issue for our society. Demand for services is high at a time of funding constraints and with a limited number of beds and service provision. This has a significant impact on the well-being of UK citizens and the country’s prospects for economic growth: around 70 million working days per year are lost due to mental health-related illness.

If we are to tackle the current challenges we must improve patient outcomes and access to mental health services.

There is widespread consensus that we need to achieve parity of esteem for mental healthcare with physical healthcare.

This can be achieved by commissioners and providers, both NHS and independent sector, working together towards one common goal: service users having access to the best care and treatment possible.

It will take resource and hard work but I am confident that by working together we can reduce waiting times and ensure that patients step-down into settings which are appropriate for their needs. The Independent Mental Health Services Alliance (IMHSA) believes that both patient access to care and outcomes can be improved. In order to achieve this we must remove the funding and commissioning barriers that are restricting the development of innovative and efficient services.

This report identifies some of the barriers that are in place and outlines solutions to addressing these issues, ultimately to the benefit of patients. At a time when the NHS is facing significant funding constraints and financial pressure, it is crucial to improve the commissioning system to allow for the delivery of better quality care in a cost-effective way.

FOREWORD

JOY CHAMBERLAIN, IMHSA CHAIR

Mental healthcare is a crucial issue for our society.

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It will take resource and hard work but I am confident that by working together we can reduce waiting times and ensure that patients step-down into settings which are appropriate for their needs. The Independent Mental Health Services Alliance (IMHSA) believes that both patient access to care and outcomes can be improved. In order to achieve this we must remove the funding and commissioning barriers that are restricting the development of innovative and efficient services.

This report identifies some of the barriers that are in place and outlines solutions to addressing these issues, ultimately to the benefit of patients. At a time when the NHS is facing significant funding constraints and financial pressure, it is crucial to improve the commissioning system to allow for the delivery of better quality care in a cost-effective way.
INTRODUCTION

IMHSA is a group of leading independent providers of mental health services.

We believe services for people with mental health needs must be high quality, deliver excellent health and care outcomes and enhance the patient experience. We aim to provide improved access and outcomes for people with mental health needs in a system where they can receive quality care and support in a timely manner.

Patient access to mental healthcare is becoming an increasingly important issue for the health sector. Demand for mental health services is high, but the current system is unable to cope with patient needs. This means that patients can face a long wait to access services, during which time their condition can deteriorate, making their eventual treatment more intensive and expensive.

The last and current governments have made parity of esteem for mental and physical health, along with improved funding and provision of mental health services, a priority. However, significant barriers to patient access to mental healthcare remain, such as the moratorium on the commissioning of new specialised services and the continued use of unaccountable block contracts.

Providers, commissioners and government must work together to find solutions to these issues. This report offers some concrete policy solutions to system barriers which we hope will be taken up by the government, NHS England and Monitor. This will help to drive improved patient outcomes and access to mental healthcare.

Provision of effective mental healthcare is vital to prevent unnecessary escalations of mental health problems, particularly given the huge impact of mental health on wider society. Around 70 million working days were lost to mental illness in 2013, costing the UK economy up to £100 billion in resultant losses. Research has shown that around 90 per cent of the UK prison population have common mental health problems, such as anxiety or depression, with over 70 per cent suffering from two or more mental health disorders. Ensuring mental health services are adequately funded and removing unnecessary barriers in the commissioning process can therefore make significant financial savings in the mid- to long-term. In addition, it will boost economic growth through improving the wellbeing of the UK workforce and enhancing productivity.
METHODOLOGY

To develop this report, IMHSA has undertaken a detailed analysis of data obtained from parliamentary questions, the Health and Social Care Information Centre (HSCIC), MyNHS, NHS England and Monitor. We have also sourced data from other third party groups including the eating disorder charity Beat and NHS England’s Mental Health Taskforce.

Alongside this we have drawn from data and case studies from our own members, as well as undertaking interviews with ten NHS England case managers from around the country and one Mental Health Programme of Care Lead. This has enabled us to obtain a unique, commissioning-focused perspective of the challenges facing mental healthcare.

Further detail and sources can be found in the appendices.
EXECUTIVE SUMMARY

Mental health is now at the forefront of the health policy agenda. However, mental healthcare has suffered from years of disinvestment and a lack of parity with physical healthcare.

Patients are currently facing long waiting times, during which time their condition can significantly worsen. This is particularly dangerous for patients suffering from eating disorders who can be put at serious risk by a lack of treatment.

Others are finding themselves in provision that is no longer suitable, unable to step-down to more appropriate care. It is therefore essential that action is taken to drive improvements in patient outcomes and access to care.

MENTAL HEALTHCARE DEMAND AND FUNDING CONTEXT

Both IMHSA members and the NHS England case managers we interviewed are seeing high demand for services. This is reflected in the high occupancy rates NHS mental health trusts are experiencing: our research has found that 39 per cent of trusts were recently classed as having occupancy rates that are “too high”.

All but one of our case manager interviewees reported that high demand was a key cause of high waiting times, with one noting that heavy caseloads mean that they constantly feel as though they are “firefighting”. This high demand is also leading to the commissioning of out of area placements.

Alongside high demand, funding has failed to meet sector needs. Funding boosts, like the additional £30m for eating disorder services, are welcome. However, such investments do not go far enough to address the wider funding constraints faced by the sector.

IMHSA’s research has found that (for those mental health trusts for which data is available):
- In 2014/15 NHS mental health trusts had an overall deficit of £48.9m.
- NHS mental health trusts saw a deficit increase of 6.3 per cent on average between 2013/14 and 2014/15.
- 31 mental health trusts were in deficit in the first quarter of 2015/16.

In the context of a predicted £2bn deficit for NHS trusts in 2015/16, this situation is likely to continue, despite
reported plans to increase mental health spending in 2015/16.

IMHSA members and some of the case managers interviewed have also seen the impact of funding constraints. This has been particularly apparent for members regarding the pricing rules set out in National Tariff guidance which have failed to take into account the differential cost base of mental health.

**COMMISSIONING CONTEXT: SYSTEM BARRIERS**

In the context of high demand for services alongside continued funding constraints, the commissioning system has to operate efficiently and effectively to meet patient needs. However, currently this is not possible, resulting in delays to patient access to appropriate care.

Delayed discharges are a key problem for patient access to care – preventing patients from moving down the care pathway and new patients from accessing beds. IMHSA has found that between 2013/14 and 2014/15, the average number of days of delayed discharge per month for trusts providing mental health services increased by 22.2 per cent.

These findings were reiterated by all case manager interviewees who identified delayed discharges as a cause of high waiting times, with funding for local bed capacity often noted as an issue. Several case managers also noted that these capacity problems were caused by patients from other regions being placed out of area into their beds. Cuts to community care are thought to exacerbate the situation.

Delayed discharges are impacting on patient access to care, but they are symptoms of wider commissioning system barriers. IMHSA has identified three main system barriers that are negatively impacting patient outcomes and access to care.
1. UNACCOUNTABLE BLOCK CONTRACTS

Under a block contract a provider is paid a lump sum fee to offer services to a certain patient population for a fixed period of time. Some block contracts can offer efficient access to services for patients but poorly monitored, managed and defined – unaccountable – block contracts limit transparency and patient choice.

Our analysis suggests that block contracts are a contributing factor to increased delayed discharges. It found that in 2014/15 delayed discharges were a third higher in mental health trusts with 100% block contracts than those trusts providing mental health services without a block contract.

NHS England has previously stated that unaccountable block contracts should be phased out for mental health – but this has not been achieved.

The existence of such contracts means that other providers are not able to offer services to that patient population. We believe that this encourages complacency as providers with unaccountable block contracts are guaranteed to receive service commissions with little oversight.

This was reflected in our case manager interviews. One noted that block contracts can mean “that there is an NHS monopoly on admissions so they can be quite lazy”, while another noted they limit commissioners’ abilities to switch providers if service flexibility is needed.

It should be noted that it is commissioners rather than providers who make decisions regarding the use of block contracts. This can cause particular issues when block contracts are recommissioned, or ‘rolled over’, without adequate evaluation or due attention to improvements that could be made.

2. STEP-DOWN CARE, FUNDING STREAMS AND WAITING TIME STANDARDS

A further cause of delayed discharges and limited access to care is the difficulty enabling patients to step-down from secure, specialised inpatient settings to non-specialised and community care. This is caused by patients having to move through different commissioning budgets as specialised services are commissioned by NHS England and non-specialised are commissioned by CCGs.

IMHSA members have found that this can create blockages as negotiations take place regarding funding and which setting is most appropriate for the patient. This experience was also reported by the case managers. They noted a lack of integration and community service investment as a key cause of delayed discharges, with CCGs often reluctant to take on patients they perceive to be costly. This suggests that a more streamlined commissioning system with clear responsibilities would help to drive improvements.

In addition, it is clear that the development of waiting time standards for all mental health conditions would help bring clarity
and transparency to commissioning decisions. This will be to the clear benefit of patients.

3. MORATORIUM ON NEW SPECIALISED SERVICES
The moratorium on the commissioning of new specialised services was introduced in 2013 to address concerns about overspending on specialised services. It remains in place, despite the need for increased bed availability.

IMHSA members have experienced difficulties as a result of the moratorium as we are unable to offer new, efficient services and pathways to patients where they are needed. Several case managers also noted the negative impact of the moratorium and highlighted a number of service areas that need to be developed in their areas. These included personality disorder services and Child and Adolescent Mental Health Services (CAMHS). This can only be achieved, and patient demand met, if the moratorium is removed.

COMMISSIONING CONTEXT: BEST PRACTICE
Alongside addressing commissioning barriers it is also important that NHS England and the mental health sector take forward existing examples of best practice to drive system improvements.

IMHSA members are willing partners for the NHS and work hard to ensure that they are able to offer the quality services required. Partnership working, as demonstrated by the Forward Thinking Birmingham model, is a key means of creating more integrated care and tackling some of those system barriers identified.

The positive role that the independent sector can play in supporting the NHS was recognised by the case managers. Many noted that the independent sector has similar, and sometimes better, outcomes as the NHS and is generally seen as being no more expensive.

The independent sector wants to share expertise as well as learning from NHS providers. More partnership working will ensure better use of limited mental health funding, and ultimately improve outcomes for patients.

In light of these findings, IMHSA has identified eight key recommendations that we believe, if implemented, will improve patient outcomes and access to mental healthcare.
RECOMMENDATIONS

1. The government must ensure fair funding for mental health services to address historic disinvestment in the sector.

2. The pricing rules set out in the 2016/17 National Tariff guidance must take into account the different cost base of mental healthcare and ensure that local pricing for mental health is properly implemented.

3. NHS England must urgently phase out the use of unaccountable block contracts in mental healthcare.

4. The government must ensure that investment in community care is not at the expense of inpatient services which are facing high demand.

5. NHS England must set out clear commissioning responsibilities for mental healthcare so that CCGs and NHS England commissioners understand who is responsible for a patient’s care.

6. NHS England must introduce waiting time access standards for all mental health inpatient services.

7. NHS England must make it a legal requirement that urgent referrals for admission are fully funded, without regard to any centrally imposed moratorium on new beds.

8. NHS England should encourage NHS providers and the independent sector to work together in partnership to offer more integrated care for patients.
MENTAL HEALTHCARE DEMAND AND FUNDING CONTEXT

Following work undertaken during the last government, mental health is now an issue that is, rightfully, at the forefront of the health policy agenda.

Mental healthcare has suffered from years of disinvestment and a lack of parity with physical healthcare which has resulted in poor patient outcomes and limited access to vital services.

We welcome the government’s clear intention to drive improvements in mental healthcare, particularly focusing on increased funding for Child and Adolescent Mental Health Services (CAMHS). However, despite these good intentions, funding remains insufficient, demand remains high and commissioning barriers remain in place.

DEMAND
IMHSA members are seeing consistently high demand for services and this is reflected in both our analysis of NHS mental health trust occupancy rate data and the experiences of the NHS England case managers we interviewed.

Figure 1, based on MyNHS data for the 59 mental health trusts shows:
• 39 per cent of trusts were classed as having occupancy rates that are “too high”.
• This represents 23 trusts, ten of which had a 100 per cent occupancy rate.

• Only 8 trusts (13 per cent) received a “good” performance rating, with occupancy levels between 76 and 90 per cent.

Yet even occupancy rates within this level could be seen as too high.

These findings are reflected in the views of case managers, who have seen significant challenges caused by patient demand.
All but one of the case managers we interviewed stated that high demand was a significant cause of long waiting times. NHS case managers spoke of having unreasonably heavy caseloads, which often led to reduced quality of care. One case manager, with responsibility for around 250 patients, expressed concern that heavy caseloads are reducing quality of care, noting “it’s impossible to know the details of each patient individually – you can’t dig deeply into a case if you have so many to deal with”.

Case managers also pointed to an increase in out of area patients, both in terms of sending and receiving patients to and from different regions. This suggests that current provision is not sufficient to meet patient demand.

One case manager noted the detrimental impact out of area placements have on patient outcomes, stating that “it massively impacts on the patient if they have to go miles away from home, and can be very difficult for the patient, family and carers.”

Out of area placements create additional blockages in the care pathway, by preventing a smooth step-down process for patients. Another case manager described how patients who go out of area often get “lost” in the system.

Clearly, high demand for mental health services is creating difficulties for commissioners and therefore patient access to care. Patients are well aware of this. 52 per cent of respondents to an NHS England Mental Health Taskforce survey of service users, their families and mental health professionals placed access in their top three priorities for change in mental health.

“I used to think of patient case management as air traffic control, where I had oversight of patients wherever they were in the country and could draw them back into the locality where appropriate. Now there is not enough local ownership of patients who are placed out of area, so I have to rely on colleagues in other parts of the country to care for them.”

NHS ENGLAND CASE MANAGER

FUNDING
Mental health has seen significant disinvestment in recent years. The government has announced a series of funding boosts to mental health services. However, when scrutinised more closely, these have failed to provide the funding the sector needs.

For example, in the March 2015 Budget, the
coalition government pledged to spend an additional £1.25bn on improving mental health services, predominately those for children and young people, up to 2020. This was due to be split evenly, £250m a year, but the government has since confirmed that only £143m will be spent in 2015/16.

Areas targeted for this £143m include improving CCGs’ local services, expanding the IAPT programme for children and young people, improvements to perinatal mental healthcare and investment in inpatient services for children and young people. In addition, NHS England has also recently confirmed £30m of funding to improve eating disorder services for children and young people, with the aim of 95 per cent of patients being seen within four weeks or one week for urgent cases by 2020. This will be recurrent funding over the next five years.

These types of funding boosts are positive, however they will not address the wider funding constraints faced by the sector, or the issues created by commissioning system limitations that will be discussed later.

IMHSA’s research has found that (for those trusts for which there are figures available) in 2014/15 NHS mental health trusts had an overall deficit of £48.9m. This breaks down to an average deficit of £1.19m per trust, an increase of 6.3 per cent from 2013/14. The figures available for mental health trusts in the first quarter of 2015/16 show that 31 trusts are currently in deficit. In the context of a predicted £2bn deficit for NHS trusts in 2015/16, this situation is likely to continue, despite reported plans to increase mental health spending in 2015/16.

The case managers interviewed generally saw capacity and bed availability as more of an issue for patient access to care than funding. However, several noted the impact of funding pressures on service provision. One noted a specific need for more funding for specialised services and two noted funding issues around the transition out of NHS England commissioned services. Placement cost was not identified as a key factor when making placement decisions. However, IMHSA members have found that funding constraints can lead to commissioners being effectively incentivised to focus on finding the ‘cheapest’ provision, rather...
than the service which can best provide for the needs of the individual patient, which would be more cost effective in the long-term.

This can lead to patients being suddenly moved from an independent setting because a ‘cheaper’ NHS bed has become available, even if it would be in the patient’s best interest to remain in their existing, stable placement. This appears to be an outdated attitude as the majority of our case manager interviewees stated that they perceived the independent sector to be the same price as the NHS.

“There is constant pressure on budgets to provide the same or better value with a lot less money. This impacts on staffing resource and quality of care.”

NHS ENGLAND CASE MANAGER

IMHSA members have also seen that the funding pressures described above have been exacerbated in recent years by the pricing rules set out in National Tariff guidance. Previous tariffs have linked deflations inappropriately to local price setting for mental health services, failing to take into account the different cost base of mental healthcare. Although the differential tariff has been removed to ensure parity between acute and non-acute services, parity of tariff deflator does not equal a parity of esteem.

The ongoing tariff review process offers Monitor the opportunity to take steps to rectify this and ensure that mental health receives the funding it needs. The tariff is a shared responsibility between Monitor and NHS England. In addition to any changes made by Monitor, NHS England should give direction to local NHS area teams to achieve parity of esteem in mental health contracts.

Overall patient demand is high and funding is not yet able to provide the level of support required to meet this. Increased investment is key, but there are also other commissioning reforms that should be addressed to bring about the improvements to access needed. These will be discussed in more detail in the next section.

Recommendation 1: The government must ensure fair funding for mental health services to address historic disinvestment in the sector.

Recommendation 2: The pricing rules set out in the 2016/17 National Tariff guidance must take into account the different cost base of mental healthcare and ensure that local pricing for mental health is properly implemented.
COMMISSIONING CONTEXT: SYSTEM BARRIERS

In the context of high demand for services alongside continued funding constraints, it is the commissioning system that has to operate efficiently and effectively to ensure that patients are able to access the services they need, when they need them.

However, the current system is not able to meet patient needs, resulting in delays to patient access to appropriate care. This is potentially detrimental to patients’ outcomes.

DELAYED DISCHARGES

The Crisp Commission on Acute Adult Psychiatric Care’s interim report (July 2015) identified delayed discharges as a key barrier to patient access to care. IMHSA’s research corroborates those findings.

We have found that between 2013/14 and 2014/15, the average number of days of delayed discharge per month for trusts providing mental health services increased by 22.2 per cent. This indicates that delayed discharges are having an increased impact on patients’ access to appropriate care.

All of our case manager interviewees identified delayed discharges, along with high demand (all but one interviewee), as a cause of high waiting times. Many noted local bed capacity as an issue.

In addition, several case managers noted that while their area technically had enough beds for the local patient population, they saw capacity problems as a result of patients from other regions being placed out of area into their beds.

“If we only had patients from the [area] there would be an abundance of beds. However, we get a lot of out of area patients, so this can create problems getting [local] patients into beds.”

NHS ENGLAND MENTAL HEALTH PROGRAMME OF CARE LEAD
These capacity problems caused by out of area placements are apparent despite all but one of our interviewees stating that a placement’s location and proximity to a patient’s home were important considerations when making placement decisions.

There may be occasions when it is more appropriate for a patient to receive care out of their local area. This may be due to their personal circumstances or the specialist nature of the required treatment. IMHSA members find that their services are often commissioned when a local provider is unable to meet the specialised needs of a particular patient.

There are clearly difficulties with patient access to services. Delayed discharges and a lack of capacity are immediate causes of this. However, they are themselves symptoms of wider issues that IMHSA has identified within the commissioning system.

**UNACCOUNTABLE BLOCK CONTRACTS**

IMHSA has undertaken detailed research into the impact of unaccountable block contracts on patient access to care.

“Our analysis has found that in 2014/15 delayed discharges were a third higher in mental health trusts with 100 per cent block contracts than those trusts providing mental health services without a block contract.

Under a block contract a commissioner states that a provider is paid a lump sum fee to offer services for a fixed period of time. Some block contracts can offer efficient access to services for patients and stability for providers. However, poorly commissioned, monitored, managed and defined – unaccountable – block contracts limit transparency and patient choice.

NHS England has previously stated that unaccountable block contracts should be phased out for mental health – but this has not been achieved.

“The independent sector … is no longer seen as the enemy or as competition but as an essential provider, providing services where local NHS providers can’t or won’t.”

NHS ENGLAND CASE MANAGER
The commissioning of such contracts means that other providers are not able to offer services to that patient population – even if they can better meet local patient demand or offer better value for money.

Our analysis suggests that block contracts are a contributing factor, amongst others, to increased delayed discharges. Our research shows that:

- Mental health trusts whose services were commissioned with a 100 per cent block contract in 2014/15 had on average 31 per cent more days of delayed discharge per month than those trusts providing mental health services without a block contract.
- Mental health trusts whose services were commissioned with a block contract in 2014/15 had on average 17 per cent more days of delayed discharge per month than those trusts providing mental health services without a block contract.

These concerns about the use of unaccountable block contracts were reflected in some of our case manager interviews. While some noted the benefits of block contracts, for example in simplifying funding, many caveated their comments with concerns including the potential for complacency and impact on patient choice.

As one case manager said, “[block contracts] have impacted on patient choice, because of the expectation that patients will fit within a particular unit that fits in a particular patch, when there may be a better service just down the road”.

“[block contracts] have impacted on patient choice, because of the expectation that patients will fit within a particular unit that fits in a particular patch, when there may be a better service just down the road”.

“We keep a very close eye on block contracts, as we are aware of the potential risks of complacency. They require regular and assertive management.”

NHS ENGLAND MENTAL HEALTH PROGRAMME OF CARE LEAD

Even those case managers that thought block contracts should remain in place noted the need for more flexibility and improved individualised care. For example, one case manager stated that it would be useful “if there was more flexibility, so if a provider was struggling a bit we could switch provider more easily”.

As one case manager, from an area where contracts have been improved, said, “Now there is an equal contract for NHS providers and the independent sector it is much better, as if we feel that one of the independent providers could meet patients' needs better then we have the option to choose them. Before, we had to fill block contract beds first.”
Recommendation 3: NHS England must urgently phase out the use of unaccountable block contracts in mental healthcare.

**STEP-DOWN CARE, FUNDING STREAMS AND WAITING TIME STANDARDS**

A further cause of delayed discharges and limited access to care, is the difficulty in enabling patients to step-down from secure, specialised inpatient settings to non-specialised and community care.

NHS England is responsible for commissioning specialised services while CCGs commission non-specialised. This means that in order to step-down from inpatient care, patients must move through different commissioning budgets.

IMHSA members have found that blockages can be created when specialised service commissioners and CCGs have to negotiate as to what setting is most appropriate for a patient and who should be funding this. Not only does this make it difficult for patients to step-down, it also prevents new patients accessing inpatient services in a timely manner.

This experience was reiterated by many of the case managers who identified a lack of step-down/community provision and issues moving patients between NHS England and CCGs, as a key cause of delayed discharges.

For example, one case manager stated “we need a major drive around collaborative commissioning. There is no

**IMHSA MEMBER CASE STUDY: STEP-DOWN DIFFICULTIES**

We have recently had patients that have struggled to move on due to barriers presented by the home team. These include:

- Home team difficulty identifying appropriate patient housing.
- Conflicts about who is responsible for funding leading to funding not being agreed and our patients unable to step-down.
- Issues identifying/maintaining care coordinators and conflicts between teams as to who the care coordinator is and who is responsible for identifying the patient’s next placement.
- Care coordinators overwhelmed with caseloads struggling to find time to complete a housing/placement search.

This led to one of our patients being on a waiting list of over 200 people for mental health services in their area. Following the departure of their original care coordinator, the patient had no coordinator to support them as a replacement could not be found.

There have also been issues around a lack of services for patients upon discharges. Several of our patients have said that they fear discharge due to the lack of aftercare services available in their area.
real incentive for NHS England and CCGs to work together. There is no financial integration as they now have separate budgets. We need to use money creatively so that it is transferred to follow the patient."

“The prime reason [for delayed discharges] is a lack of community care provision. This is particularly problematic for secure patients who are ready to move down the pathway, as community providers are often unable or unwilling [e.g. through lack of training] to take them on.”

NHS ENGLAND CASE MANAGER

This statement reflects a key concern for many of the case managers that a lack of alignment between inpatient and community services makes step-down and discharges difficult. One case manager noted that “we need a robust community system, as this would stop delayed discharges and blocked pathways. We need to offer bespoke packages within the community, particularly for forensic patients.”

“The government needs to reinvest in community services to reduce pressure on hospital services.”

NHS ENGLAND CASE MANAGER

Another case manager noted that “CCGs have limited budgets and it can be a real problem trying to get someone out of secure care, as CCGs don’t want to pay for the package of care required. This can be quite costly so CCGs are reluctant and tend to hold off on this, which delays patients moving on.”

In recent years there have been moves to close inpatient beds in order to encourage the development of more community services.

The fact that in October 2015 39 per cent of mental health trusts had occupancy rates that were “too high” (96 per cent and above) demonstrates that such services still have a vital role to play.

This shows the need for alignment in step-down care and inpatient care. Community care is extremely important, but investment in this area cannot come at the expense of inpatient care. This is especially the case given the large demand inpatient services are seeing at the present time.

A key element to ensuring the system works well together will be the introduction of waiting time standards for all mental health inpatient services. The government has made a welcome start towards this. NHS England’s Five Year Forward View made clear that waiting time standards are an important part of creating parity of esteem between mental and physical health. CCGs will now have to submit plans for introducing waiting time standards for specific conditions and will be assessed on this in early 2016.

However, this does not go far enough, particularly for inpatient services. For a large number of conditions that require inpatient treatment, time is of the essence and the introduction of waiting time standards would make a significant positive impact on patient care and outcomes.
Recommendation 4: The government must ensure that investment in community care is not at the expense of inpatient services which are facing high demand.

Recommendation 5: NHS England must set out clear commissioning responsibilities for mental healthcare so that CCGs and NHS England commissioners understand who is responsible for a patient’s care.

Recommendation 6: NHS England must introduce waiting time access standards for all mental health inpatient services.

MORATORIUM ON NEW SPECIALISED SERVICES

The moratorium on the commissioning of new specialised services was introduced in 2013 to address concerns about overspending on specialised services after NHS England took responsibility for the specialised services budget.

The moratorium is still in place, despite the need for increased bed availability to ensure patients are able to access services. There are concerns that the moratorium is leading to beds being opened and subsequently not commissioned.

IMHSA members have experienced difficulties as a result of the moratorium. We want to offer new, efficient services and pathways to patients to ensure that they are able to access quality care and do not suffer from long waiting times.

For example, one member is building a new hospital. It is currently gathering feedback from the local NHS England team, as well as local and regional CCGs, on the sorts of services that are needed in the area and will be funded. However, because of the moratorium, it may not be possible to develop specific new and innovative service lines, despite indications that there may be need within the local area.

Only one of the case managers interviewed noted any positive impact from the moratorium. Others commented that there had been negative impacts including a “pervasive conservative culture” that is resistant to change.

“The moratorium has led to a huge amount of beds being opened up and not commissioned.”

NHS ENGLAND MENTAL HEALTH PROGRAMME OF CARE LEAD

In addition, many of the case managers identified service areas where more provision was needed. Four case managers specifically noted personality disorders as a key service in need of additional development in their area. CAMHS and female low secure services were also identified.

There is a clear need for new services, and an appetite to offer them from providers. However, unless the moratorium is removed, these services cannot be developed or commissioned.
This policy prevents patients from accessing much-needed mental healthcare and also reduces patient choice. NHS England may feel that it cannot remove the moratorium as it does not have funding to commission additional services. However, the current system is an inefficient use of funding that could be better used, and patient access to care improved, if the moratorium were lifted.

This would help reduce waiting times and delayed discharges and give case managers the flexibility they need to commission services to meet patient demand.

**Recommendation 7:** NHS England must make it a legal requirement that urgent referrals for admission are fully funded, without regard to any centrally imposed moratorium on new beds.
FOCUS ON: EATING DISORDER SERVICES

Increased provision of eating disorder services has been a focus for the new government. NHS England recently confirmed £30m of recurrent funding for five years to improve eating disorder services for children and young people. This is aimed at ensuring 95 per cent of patients are seen within four weeks, or one week for urgent cases, by 2020.

Tackling eating disorder waiting times is essential. IMHSA members are aware of several cases where a seriously ill patient has had to wait an unacceptable amount of time to receive treatment and suffered a deterioration in their condition as a result.

At the start of 2015 one member had over 50 patients on their eating disorder waiting list, including one with a Body Mass Index (BMI) of 12.3. The average BMI of these patients was 14.04. Adults with anorexia generally have a BMI below 17.5 so many of these patients were already seriously ill while waiting for care. Sadly during this year this provider has seen three people with eating disorders pass away while waiting to access treatment. This is a tragic outcome that may have been avoided if patient access to care had been improved.

These experiences were mirrored by a recent Beat survey of almost 500 eating disorder sufferers. This found that of those that had received outpatient treatment, 30 per cent waited longer than 18 weeks and 26 per cent of those had to wait 6 months or longer from referral to start of outpatient treatment. Perhaps most significantly, 41 per cent strongly agreed, and 30 per cent agreed, that the severity of their eating disorder increased while on the waiting list.

In addition, two of our case manager interviewees noted eating disorder patients as specifically suffering from high waiting times in their area. One noted particular pressure on adult eating disorder beds and said this had been exacerbated by the closure of two local units to admissions pending service improvements. Another respondent noted plans to add four new eating disorder beds to the existing service to tackle a reliance on out of area CAMHS eating disorder beds.

Eating disorder services are a clear example of how barriers in the commissioning system are limiting patient access to care and positive outcomes. Demand for services is not being met, putting patients at risk of deterioration when they are waiting for care.

The moratorium on new specialised services is preventing the creation of new beds to meet this demand, while difficulties stepping down patients are creating delays and inappropriate follow up care. This is ultimately to the detriment of patient access to care and their chance to recover.
THG recently put together an outreach proposal as part of the discharge package for patient AA. Patient AA had been an eating disorder patient at one of our hospitals for six months. During this time, AA had made significant progress on their individual pathway and completed many of their personal goals. As such, the clinical team believed AA was in a position to commence with the discharge plan and facilitate integration back into AA’s family setting.

As part of the discharge plan, we identified, with AA, that she would benefit hugely from continued occupational therapy and key worker support. The clinical team, patient AA and their family were in agreement that if a bespoke package, tailored to support AA’s individual needs, could be put in place, it would support continued progress on the patient’s recovery journey.

Unfortunately, AA’s local CAMHS services were unable to support the patient’s needs in the community at the time of discharge and excessive travel would have been a significant issue for this young person (she was having to get 3 separate buses over a long distance to access what support there was on offer in the community and it was felt that there was a risk that she would not fully access on this basis). Therefore, we offered a time limited community support package, to promote successful transition back to the community.

The proposal incorporated nurse and occupational therapy assistant visits to the patient at home, as well as fortnightly family therapy sessions, carried out via Skype, for the six week duration of the programme. All information regarding the patient’s progress would be provided directly to the community team to ensure a seamless handover. This would have been in place for a matter of a few weeks only, with reducing frequency of visits. The cost of this short-term service was only the equivalent of 3 bed nights in a CAMHS hospital bed.

Unfortunately, we were unable to gain agreement for the outreach proposal as the service fell between two funding streams. NHS England was clear that they would not commission services outside of Tier 4 inpatient services and the CCGs stated that they ‘already’ commission services that should cover this community support. Therefore, we were unable to gain approval in time and patient AA was discharged back to the community.

We have since been advised that patient AA has been readmitted into another Tier 4 inpatient service, within 3 months of her discharge home.

This is a very disappointing outcome for the patient, and an example of a young person being failed by the system. We believe this setback in recovery could have been avoided with the implementation of an innovative, tailored but inexpensive service spanning six weeks.

The readmission to hospital will be a much greater cost both in terms of funding and patient AA’s recovery. These circumstances will undoubtedly have caused a great deal of distress and anguish for patient AA.
Alongside addressing the identified commissioning barriers it is also important that NHS England and the mental health sector take forward existing examples of best practice. This will further support patients to access care and achieve positive outcomes.

**NHS AND INDEPENDENT SECTOR PARTNERSHIPS**

The past few years have seen welcome moves towards more integrated commissioning and service provision, with an increasing number of successful and innovative partnerships between the NHS, independent sector, and third sector. For example, in Birmingham an innovative partnership, Forward Thinking Birmingham (see case study), has seen the NHS, third sector, and independent sector come together to provide mental health services for 0-25 year olds. This will provide services ranging from inpatient to community care, and the aim is to offer a more joined-up approach to commissioning.

This type of model is key in tackling the barriers posed by delays in step-down care and moving patients between commissioning responsibilities and funding streams.

IMHSA members are willing partners for the NHS and work hard to ensure that they are able to offer the quality services required. The positive role that the independent sector can play in supporting the NHS was recognised by the case managers, all of whom commissioned services from the sector.

The majority of our case manager interviewees stated that they perceived the independent sector to be the same price as the NHS. Several noted that in terms of patient outcomes the independent sector and NHS are “very similar”, with one manager claiming it was not possible to separate the two.

Two case managers noted more positive outcomes from the independent sector, including in terms of ensuring patients are moved on more quickly and are not delayed.

Partnership working can also be beneficial in terms of the sharing of expertise. For example, one member setting has worked productively with a local NHS hospital.

"The independent sector is more flexible, and can often meet demands quicker, with speedier assessments.”

**NHS ENGLAND CASE MANAGER**
and other emergency services to train staff in caring for patients with mental health conditions who need physical care following instances of self-harm (see case study).

These are just some examples of the positive partnership working and best practice sharing that are emerging in the mental health sector. The NHS should be encouraging these types of models as an important means of breaking down some of the commissioning barriers identified as restricting patient outcomes and access to care.

**Recommendation 8:** NHS England should encourage NHS providers and the independent sector to work together in partnership to offer more integrated care for patients.

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**PRIORY GROUP CASE STUDY: FORWARD THINKING BIRMINGHAM**

In February 2015 Forward Thinking Birmingham was announced by Birmingham South Central Clinical Commissioning Group as the preferred provider for a five year contract to deliver mental health services for children, young people and young adults.

Forward Thinking Birmingham is a NHS, third sector and independent sector partnership led by Birmingham Children’s Hospital. It includes Worcestershire Health and Care NHS Trust, the Priory Group, Beacon UK and The Children’s Society.

Forward Thinking Birmingham was chosen by the CCG and the children and young adults involved in the process for its innovative approach and range of entirely new services and facilities, focused around the individual needs of 0-25 year olds.

Each member offers different services and expertise, for example Priory provides inpatient and rehabilitation services, Worcestershire Health and Care NHS Trust offers the necessary community adult mental healthcare, while Beacon UK provides care management services.

The service is based around prevention, choice and personalised care and the partnership approach will help to address the problems in Birmingham, including disjointed and fragmented care provision, complicated service models, long waiting lists and increasing patient demand. This will be achieved through a new integrated ‘one care plan’ patient management system that patients can also access.

Overall this approach should address commissioning barriers and ensure that patients are able to access the care they need, when they need it.
IMHSA MEMBER CASE STUDY: PARTNERSHIPS IN CARE - SHARING BEST PRACTICE

One of our hospitals has supported service users to lead a project which is improving the safety of patients who come to the attention of emergency services as a result of ‘self-harm’ resulting from a mental health condition.

Residents shared with staff and each other their first hand experiences of prejudice and poor care in the past when they had required treatment for ‘self-harm’. After recognising there was potential for improvement in physical healthcare in these situations, we launched a project that involved the residents personally sharing their stories in workshops held for many organisations including a GP Surgery, local A&E and local emergency services including the police and community psychiatric liaison teams.

We have seen evidence of improved turnaround time for many residents who have required medical care for minor injury caused by self-harm as well as a reduction in the incidence of self-harm among residents.

We believe this model has enabled service user empowerment, improved patient safety and experience and broken down barriers, reducing prejudice and stigma between healthcare professionals and people who self-harm.

This is true not just for residents in our hospital but for all people including those in the community who may find themselves requiring physical healthcare linked to their mental health needs.
FOCUS ON: CAMHS

Child and Adolescent Mental Health Services have been identified as an area of focus for the government, with the Conservatives continuing the work started under the Coalition. An additional £1.25bn funding for CAMHS over the course of the current parliament was confirmed in the March Budget. This aims to provide treatment and support to an additional 110,000 children and young people with mental health needs, as well as improving access to support for pregnant women and new mothers.

There are, however, concerns that this funding is insufficient to meet the growing demand for CAMHS, particularly as the expected first instalment of £250 million has not been made fully available for 2015/16. Bringing down CAMHS waiting times and improving access to services is crucial to ensuring the best possible outcomes for young people with mental health needs, and disinvestment is preventing this.

These concerns were reflected in the CQC’s most recent State of Care report, which confirmed that “accessing beds is a particular problem... with children being placed in beds miles away from home or on adult mental health wards when there are no beds available elsewhere”. The report found that patients under the age of 16 spent an average of 300 bed days in adult mental health inpatient settings per month during 2014-15: the equivalent of 10 children per month being placed in inappropriate settings.

Recent work from the NSPCC has also found that one fifth of all children referred to local specialist NHS mental health services are rejected for treatment.

IMHSA’s case manager interviews reflected these concerns. One case manager noted that “there has been a real increase in demand for CAMHS”, leading to increasing waiting times.

“We know that there are kids waiting, but there just aren't the beds.”
NHS ENGLAND CASE MANAGER

Another case manager described how a lack of funding for beds resulted in many children and young people suffering from mental illness having to be sent out of area, away from friends and family. This can be a frightening experience for younger children in particular.

In fact, a number of case managers identified CAMHS as a service that saw a particularly high number of out of area placements.

The Future in Mind Report by the Children and Young People’s Mental Health Taskforce also noted the importance of ensuring young people are able to access services close to home. It recommended moving away from a tiered system, to encourage
more integrated care and reduce complex commissioning arrangements.

IMHSA believes that, alongside removing barriers like unaccountable block contracts, partnership working models are key. The case study below provides an example of how such models can help produce improved outcomes for CAMHS patients.

There is widespread agreement that failure to support people early on in life leads to deep-set problems later on, which require expensive long-term interventions. The

**PRIORY GROUP CASE STUDY:**
**PARTNERSHIP PROJECT WITH SUFFOLK COUNTY COUNCIL**

Prioriy Group was awarded funding from the Department for Education’s Children’s Services Innovation Fund to trial a unique approach to caring for young people with mental health needs in partnership with Suffolk County Council.

The project is piloting an integrated health, education and care service for young people in the area. It brings together leading experts from education, healthcare and social services to integrate care around young people with mental health needs and create individualised packages of support.

The aim of the project is to reduce the number of adolescents sent far away from home for their care, reduce the need for young people to be admitted to mental health wards and increase educational opportunities by supporting the integration of young people back into mainstream schools, colleges and the workplace.

The provision of a comfortable environment close to home will mean these young people have access to the tailored support they need, leading to improved outcomes in both the short- and long-term.

Children and Young People’s Mental Health Taskforce reported that 75 per cent of mental health problems in the adult population start before the age of 18.

This means that it is vital that commissioning barriers are removed to ensure that young people are able to access a range of appropriate care options when and where they need them.
Patient outcomes and access to mental healthcare must be improved. In the context of high demand, funding constraints and limited bed availability we must remove commissioning barriers and develop a more integrated system.

Patients are currently being detrimentally impacted by delayed discharges and out of area placements. These ultimately stem from a system that is unable to cope with high demand.

To tackle this we must remove commissioning barriers like the continued use of unaccountable block contracts and the moratorium on commissioning new specialised services. We must ensure that the funding system provides the investment and support providers need.

It is particularly important that the link between NHS England commissioned services and CCGs is improved, alongside targeted investment, to ensure that patients are able to step-down and receive the support they need in the community. Joined-up working is also key here and the independent sector is a willing partner for the NHS.

We hope that the government, NHS England and Monitor will take forward our recommendations. We look forward to working with them and the wider sector to ensure they are implemented and ultimately to improve patient outcomes and access to mental healthcare.
As part of our data gathering for this report IMHSA interviewed 10 NHS England case managers and a Mental Health Programme of Care Lead.

These case managers were based in the following areas:
- South East - 4 interviewees
- North East - 2 interviewees
- North West hub - 3 interviewees
- West Midlands - 1 interviewee
- East Midlands - 1 interviewee

Other key data sources include:
- Health and Social Care Information Centre (HSCIC)
  - Mental health and learning disabilities statistics (MHLDS) (October 2014 onwards)
  - Mental health minimum dataset (MHMDS) (April 2013 - September 2014)
  - Routine quarterly MHMDS reports (October 2009 – June 2013)
- MyNHS, accessed October 2015
- Monitor
  - Performance of the foundation trust sector: year ended 30 June 2015 (9th October 2015).
  - NHS foundation trust accounts: consolidation (FTC) files 2014/15 (22nd July 2015)
- Department of Health, Annual report of the Chief Medical Officer 2013: Public Mental Health Priorities (9th September 2014)
- Trust Development Authority, overarching financial position of NHS Trusts for the first quarter of 2015/16 (9th October 2015)
- NHS England
  - 2013-14 CCG Programme Budgeting Benchmarking Tool (5th June 2015)
  - 2012-13 Programme budgeting benchmarking tool (21st February 2014)
APPENDIX 2 – RECOMMENDATIONS

1. The government must ensure fair funding for mental health services to address historic disinvestment in the sector.

2. The pricing rules set out in the 2016/17 National Tariff guidance must take into account the different cost base of mental healthcare and ensure that local pricing for mental health is properly implemented.

3. NHS England must urgently phase out the use of unaccountable block contracts in mental healthcare.

4. The government must ensure that investment in community care is not at the expense of inpatient services which are facing high demand.

5. NHS England must set out clear commissioning responsibilities for mental healthcare so that CCGs and NHS England commissioners understand who is responsible for a patient’s care.

6. NHS England must introduce waiting time access standards for all mental health inpatient services.

7. NHS England must make it a legal requirement that urgent referrals for admission are fully funded, without regard to any centrally imposed moratorium on new beds.

8. NHS England should encourage NHS providers and the independent sector to work together in partnership to offer more integrated care for patients.