Written evidence from Mind to the Health Devolution Commission

Summary

Mind welcomes the opportunity to respond to the call for evidence for the Devolution Commission. Over the last decade, there has been an increasing focus within the NHS and other public services on devolving more powers to a local level. Such devolved decision-making can allow local areas to take ownership of the challenges they face and bring together local stakeholders, including people who use services, to come up with fresh, innovative solutions to longstanding challenges, better targeting limited resources into effective support.

However, devolution also carries risks if there is poor leadership. It can increase unwarranted variation and without strong national oversight, there is a risk that poor quality services can go unchecked or that services supporting populations that are more marginalised or stigmatised, such as people with mental health problems, will be neglected.

Mind does not take a position on any particular structural set up, and indeed there has been a tendency to focus on structures rather than on what matters to people who use services. People with mental health problems tell us repeatedly that they want:

- Timely and equal access to high quality services close to home when they need it
- To receive person-centred care over which they have choice and control, tailored to their needs and preferences, with a range of support available, such as a choice of talking therapies and non-clinical treatment options as well as places where they can feel safe when they are in a crisis
- To be listened to and treated with dignity and respect, to feel safe and to have hope that they can recover.

This needs to be the test by which devolution is judged, as with any other policy initiative. As such, Mind does not support devolution for its own sake but does support measures that result in improvements to services and support for how people with mental health problems – wherever they live. This is particularly critical given that only a third of people with mental health problems are able to access any services at all and that the quality of services all too often is very poor.

While Mind's remit means that we can only comment on the experiences of people with mental health problems, there will be people with specific physical health conditions that are underserved by the NHS and wider public services for whom very similar arguments are likely to apply.

Opportunities and benefits for mental health from greater devolution

There are a number of opportunities and potential benefits of devolution for mental health:

- Giving local bodies greater powers and responsibilities should enable decision making to be made closer to home, enabling local areas to be responsive to the needs of their local community.
- Devolution can provide a greater sense of ownership and responsibility for tackling local problems and coming up with innovative and creative solutions to entrenched problems.
- It can facilitate close partnership working in the design and delivery of services, including drawing for the expertise of the local voluntary sector.
- It can also offer opportunities to take a more preventative approach to health, aligning policies within an area to tackle to determinants of good mental health. This should enable savings across the system which can be reinvested locally across the system. Pooled budgets can also play a role in taking an upstream approach to health.
- It can facilitate better local integration between services and support for people with mental health problems, with services being able to provide holistic care as opposed to fragmented care across multiple organisations. Key beneficiaries would be people with multiple long-term conditions and those with complex needs who are supported by health, social care and perhaps voluntary sector bodies.
- Devolution could also support better multi-disciplinary workforce planning at a local level, enabling local areas to identify and recruit the right staff to match local need, as well as making sure that the local workforce is representative of local communities.
- Devolution could be a mechanism to increase the voice of local VCS organisations within decision-making structures. VCS organisations play an important role in the delivery of mental health services but could play a more prominent role in local decision-making.
- Local areas can also engage with local communities in the design of services and pathways and provide routes for people who use services to take a leadership role in shaping support in their area.

Risks and challenges for mental health from devolution

There are a number of risks and potential challenges that devolution may present for mental health:

- The obvious risk of devolution is exacerbating local variation in the quality of mental health services, entrenching a 'postcode lottery' across the country. This is already a significant concern within mental health service delivery and successful programmes to tackle poor performance have often been top-down, centralised initiatives, e.g. Long Term Plan, Five Year Forward View for Mental Health, Improving Access to Psychological Therapies, Mental Health Investment Standard.
- Where integration and cross-organisational working have been effective has often relied on the personalities and relationships of the individuals involved, either through a galvanising local leader, or a particularly collaborative group of local leaders. Again this increases the risk of local variation in the quality and availability of services for people with mental health problems.
- There is a clear tension between national accountability and local devolution: national targets and standards can be very effective mechanisms to drive

improvements and provide accountability on performance levels; mental health has too few of these when compared with other parts of the health system, and this can be seen to have had a negative impact the relative quality of services. However, national targets clearly inhibit the ability of local areas to truly determine local priorities – if all a local system's resources are directed towards meeting nationally prescribed targets, devolution is of limited value.

- Mental health services have often been the junior partner within local health systems;[1] devolution could compound this situation with large acute trusts dominating decision-making within ICS. For example, we have seen how within STP/ICSs, capital funding bids for acute services have been prioritised over those of the mental health estate, with many ICSs not even bidding for mental health capital funding.
- Historically having been predominately funded by block contracts, Mental Health Trusts have tended to raise their eligibility thresholds to balance their books, hence nearly two-thirds of people with mental problems receive no appropriate treatment. Acute trusts which have been funded according to activity have tended to run up deficits and been bailed out by DHSC or had money intended for mental health services diverted to them. Without the proper safeguards in place, such as the increasingly robust Mental Health Investment Standards, there is a risk that mental health funding will be raided once more. This had been the experience in Scotland when mental health and physical health services became single entities.
- Fundamentally, resources need to follow any further moves to devolve decision-making – devolution itself isn't a magic wand to improve services. We have seen since 2010 that local authorities have been given greater responsibilities, e.g. for public health, but without the funding to accompany it and have seen a catastrophic collapse in non-statutory services, with evidence based and highly cost effective interventions such as smoking cessation being targeted for cuts.

Detailed response

1. What does good look devolution look like?

Ultimately, good devolution for mental health would enable the delivery of what people with mental health problems tell us over and over again that they want:

- Timely and equal access to high quality services close to home when they need it
- To receive person-centred care over which they have choice and control, tailored to their needs and preferences, with a range of support available, such as a choice of talking therapies and non-clinical treatment options as well as places where they can feel safe when they are in a crisis
- To be listened to and treated with dignity and respect, to feel safe and to have hope that they can recover.

Good devolution therefore would:

1 King's Fund, Royal College of Psychiatrists (2017), Mental health and new models of care: lessons from the vanguards

- support organisations to work together to ensure the services that people receive care that meets these expectations
- provide integrated care across organisational boundaries, no matter where someone enters the system
- includes sufficient accountability mechanisms to ensure that in areas like mental health where significant improvements are needed across the country, performance is monitored and reported upon in such a way as to enable comparisons between areas
- supports the involvement of local community and voluntary groups, as well as service users in both the design and delivery of services
- Supports areas to take a longer-term, preventative approach to tackling mental health and other health inequalities

Case study: VCSE role in supporting NHS to address social impacts on mental health
Mind in Hammersmith and Fulham supported the local A&E CQUIN by providing social prescribers in A&E to assist support those patients with the highest attendance for mental health issues with social issues. The result was a 21% reduction of high intensity users presenting at A&E saving circa £60,000 per quarter. This shows the benefit that charity and community partners can provide to patients that sits outside of the medical model but has positive impact on NHS services.

a) To what extent and how could health devolution be supportive of better prevention, early diagnosis, treatment and care in mental health?

Greater devolution offers the opportunity to invest in and co-ordinate population mental health programmes such as the various Thrive programmes or local suicide prevention campaigns (see box below), and in targeted interventions aimed at groups at highest risk of developing mental health problems, such as parenting programmes for children with conduct disorder.

Devolution also provides an opportunity to align budgets across public services to achieve better mental health in the community. For example, adopting a 'mental health in all policies approach that looks ate housing, parks and green spaces, leisure and community facilities, transport, etc.

Likewise, devolved areas might want to invest additional resources into primary care so that people can get more rapid access to treatment and support before their mental health deteriorates and they need more intensive – and expensive – help. This could include having mental workers or counsellors co-located in GP services or offering interventions such as Mind's Active Monitoring service, which can provide a rapid response and prevent people from needing further support.

In terms of improving treatment and care, devolved areas will have more freedom to invest in mental health services according to need. There are opportunities to realise savings by better joining up physical and mental health care, as evidenced the enhanced IAPT service for people with Long Term Conditions. The savings for this cohort are often realised in the acute system but the intention was for the savings to be reinvested in mental services, though this hasn't always happened.

Cambridge Peterborough South Lincolnshire Mind STOP Suicide campaign - Showing how everyone can stop suicide

STOP Suicide is a CPSL Mind-led campaign that aims to build awareness around how everyone can play their part in preventing suicide in Cambridgeshire and Peterborough – and beyond.

The campaign aims to create a social movement around suicide prevention. It's a key part of the county-wide Zero Suicide Prevention Strategy, supported by local authorities, NHS teams, voluntary sector organisations, businesses and, vitally, members of the public.

The public are empowered to take the campaign messages into their community as 'campaign makers'. STOP Suicide's award-winning approach encourages communities and people to help stop suicide by:

- being alert to the warning signs
- asking directly about suicide
- helping those who are feeling suicidal to stay safe.

The campaign aims to enable direct and open conversations around the difficult subject of suicide. It seeks to break the taboo that prevents those at risk from getting the help they need.

In 2018 the campaign launched bus advertising, radio advertising, community roadshows, and a powerful film to raise awareness. It also harnessed real people's stories in the press and on social media. It's one of the most overt public campaigns around suicide prevention in the UK.

See the campaign film at: https://www.youtube.com/watch?v=8LffP0PolNQ

b) What evidence is there that health devolution leads to better mental health services and outcomes?

Mind has not undertaken any specific research on the impact of devolution in all its forms, so we can only comment based on the detailed experiences reflected by Stewart Lucas in Greater Manchester (see Appendix A for his submission).

Integrated Care Systems (ICSs) are the due to be in every area by April 2021. These devolve a far greater level of decision-making within the NHS to 42 sub-regional geographies.

A briefing from the Centre for Mental Health[2] published in February 2020 found that ICS can provide three main areas of opportunity**:**

1. **Preventing ill health**: Poor mental health can be a major contributor to poor physical health. Investing in preventing mental health difficulties could bring about improvements in overall health and generate significant savings long-term.

[2] Centre for Mental Health, 2020, Briefing 55: Integrated Care Systems and mental health

2. **Linking physical and mental health:** Having a long-term physical illness doubles a person's chances of having a mental health difficulty. Likewise, having a long-term mental illness increases a person's risk of physical ill health. ICSs can help to ensure that all physical health interventions are equally accessible to people with mental health conditions, and that people with long-term physical conditions get effective mental health support.
3. **Improving mental health services**: ICSs have the ability to tackle systemic issues in mental health service provision beyond the local level, such as in addressing the prevalence of 'out of area placements' and the overuse of long-term hospital placements for people with learning disabilities and autism under the Mental Health Act.

They also identify a number of challenges, such as whether mental health will get prioritised, how the workforce can be sufficiently expanded, and how well ICSs work in partnership with local authorities, voluntary and community groups and people who use health and care services.

Meanwhile, The Royal College of Psychiatrist's report on mental health within emerging ICS[3] found that:

- ICSs have the potential to improve patient experience, reduce morbidity and mortality rates, reduce the unmet need in mental health and innovate to go further faster. Through system-wide collaboration, there is a real opportunity to improve and join up mental health services with the rest of the health and care system and there is a strong sense that mental health trusts should be leaders, not followers, as their expertise in moving care from hospital settings into the community and working across complex health and care systems is invaluable.
- ICSs also provide an opportunity for system-wide incentives to improve mental health care, linked to outcome-based payments, either through alliance or ICP models.

The College also highlighted major challenges as remaining with ICSs.

- the viability of mental health trusts, many of which might be too small to have their voice heard within a wider system.
- In addition, there is a need to consider the current leadership capability within the mental health sector and how we can support and develop the leaders of the future.
- The pace and scale of change are also a considerable challenge and local leaders should be cautious when thinking about complex organisational change.

c) What wider determinants of the causes of mental ill-health could a devolved health system more successfully address?

See above question a)

2. How can challenges of accountability, power and control be addressed in devolved and integrated health systems?

Devolution and changes to commissioning structures have implications for the operation of the VCSE in localities as they seek to respond to align themselves to these new structures.

[3] Royal College of Psychiatrists, 2020, Improving mental health services in systems of integrated and accountable care: emerging lessons and priorities

It takes time and resources to understand and navigate new system architecture. Moreover, it can be challenging for the charity sector to secure meaningful influence with devolved health systems when they involve large numbers of other stakeholders.

Case study: Mind's involvement at a regional level in London
In London, 16 of the 19 local Minds have signed up to a collaboration at the London level and are also developing STP level alliances to allow them to respond to the changed NHS and devolved system in the city. Other charities such as Age UK also operate at the regional level.

Mind also sits on the London Mental Health Transformation Board. It is however the only charity partner on a board that hosts up to 30 stakeholders at a given meeting. The forum takes the form of programme updates and the opportunity to influence the direction of the Board's work is limited. Meanwhile the Healthy London Partnership and Thrive LDN bring partners together but whilst charities may be funded through their programmes for individual pieces of work, it is fair to say that charities are not as included in setting the agenda for work or strategy. It feels very much like a statutory partnership.

a) To what extent could health devolution empower people with mental ill-health to have more control over their care?

Like anyone else seeking support from health or other services, people with mental health problems can potentially benefit from the closeness of decision-making to services. In terms of the design of care services, it may be that devolved systems, because of a greater sense of ownership, are more invested in undertaking more extensive engagement with the public and those using services in shaping what support people want for their mental health. However, there is nothing to stop non-devolved areas for doing this too if they consider it a priority.

The challenges to empowerment of people with mental health problems are not necessarily determined by local governance and commissioning structures. Funding for and availability of services (particularly non-clinical interventions), cultures within services and the skills of health professionals to take a person-centred approach to services and support are key factors in determining whether people are able to have choice and control over their own care. People also often need support to be able to take more control over their care, particularly if they have lost confidence and become disempowered after many years in contact with services. Devolved areas would be able to invest in appropriate training for staff, support for people with mental health problems and in the types of support they want to give people greater control over their care.

b) How can local mental health leaders in devolved health systems be held accountable locally and nationally at the same time for the performance of locally integrated services?

Case study: Greater Manchester VCSE Leadership Group Memorandum of Understanding (MoU) with GM Health & Social Care Partnership
In 2016 The Greater Manchester VCSE Leadership Group agreed a Memorandum of Understanding (MoU) with the Greater Manchester Health and Social Care Partnership. Additionally, in 2017, an Accord was agreed with the Greater Manchester Combined

Authority. The MoU and Accord are five year agreements to support the 16,000 VCSE organisations that operate in Greater Manchester to engage in Greater Manchester's devolution work. The VCSE Leadership Group identified a number of priority areas in order to support sector engagement including Commissioning, Procurement and VCSE Investment. Through the MoU the VCSE has secured representation across the System, meaning that it holds seats on the Partnership Executive Board, Health and Wellbeing Board and the public reform board alongside the NHS and local authorities.

Within the Five Year Forward View for Mental Health and the NHS Long Term Plan, NHSE/I has set a national ambition and trajectory for what local areas are expected to deliver in terms of outcomes, but local areas have the freedom to determine the detail and how they go about meeting it. They will be held accountably nationally and will be offered intensive support by regional teams to achieve the national ambition. This has been effective in driving forward service improvements for those areas that are a priority within national plans, but can also lead to neglect of other important services not in the plan, and we know there is a degree of gaming of the data (e.g. hidden IAPT waits). A clear and comprehensive set of access and waiting time standards would help with this. Given the lack of focus, priority and funding given to mental health services for many years, and the lack of clout mental health often has within local systems, there needs to be continued national monitoring, evaluation and where necessary enforcement action to ensure people with mental health problems can get the help they need.

However, in most areas there has been a lack of local democratic accountability within health systems. Health and Wellbeing Boards have not had the impact that was initially envisaged for them as a place to bring together the NHS and local authorities and have been largely superseded by STPs/ICSs in terms of where the power lies. In some areas, local authorities have withdrawn from STPs, and thus the opportunity to have those cross-sector conversations has been lost. We have also heard anecdotally that there has been very little focus on public health and prevention within STPs/ICSs, a real missed opportunity.

There is also a very limited voice for local people and people using services. Healthwatch's remit only goes so far and some areas have resourced their local Healthwatch better than others. People with mental health problems tell us they find it difficult to find opportunities to influence services in their areas, and much public engagement is tokenistic and only takes place as a PR exercise after decisions have already been made. Devolved areas could choose to model high quality public engagement in understanding how services are performing and where change is needed.

The Mental Health Dashboard has been a useful tool to monitor progress at CCG, STP/ICS and national level across a range of key indicators. Local areas, whether devolved or not, should ensure they are collecting the data they need and investing in data analytics to understand patterns of service use, the demographics of those using their services and how best to target resources.

c) What should be the relationship between central government, NHSE and devolved health areas in relation to mental health?

As above, we still need national accountability to retain focus on mental health given the historic underinvestment and lack of priority given to mental health and how far behind it is in terms of the treatment gap. Whilst we have made great strides in awareness about

mental health in recent years, there is still far too much local variation in both the availability and quality of services to relinquish national oversight and direction.

Mind does not take a view as to particular type of structure should be in place, as long as it works for people with mental health problems. There would, however, seem to be a democratic role for government in setting the strategic direction of the NHS and we are disappointed that the Secretary of State is no longer using the Mandate to do this. Furthermore, the Mandate was initially envisaged as an annual set piece opportunity for the public and organisations that represent them to feed in and comment on the government's priorities. There has been no form of consultation on the Mandate, however, for many years.