

# Briefing Paper for the Health Devolution Commission

## Integrated Care Systems Best Practice Roundtable

### Health Inequalities, Children and Young People, Mental Health and Learning Disabilities

Online 3:30 to 5:30pm on 8<sup>th</sup> June 2022



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The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, British Association for Counselling and Psychotherapy, Greater Manchester Health & Social Care Partnership, West Yorkshire Health and Care Partnership, Mencap and Barnardo's.



## OVERVIEW AND KEY QUESTIONS

This is a briefing paper for Commissioners of the Health Devolution Commission in advance of the best practice roundtable to be held online at 3.30-5.30pm on 8<sup>th</sup> June 2022. The report and recording of the first roundtable can be found at <https://healthdevolution.org.uk/resources/>. This second roundtable will hear from speakers in three parts:

### Part One: Developing ICS best practice to address health inequalities

- **Professor Michael Marmot**, Director, UCL Institute of Health Equity
- **Dame Jackie Daniel**, Shelford Group and Chief Executive of the Newcastle Upon Tyne Hospitals NHS Trust (with input from **Darren Banks**, Group Strategy Director for Manchester University NHS Foundation Trust and **Roland Sinkler**, Chief Executive, Cambridge University Hospitals NHS Foundation Trust)

#### *Key Questions:*

- **Levelling up health:** Should the Government adopt the goal as proposed in Michael Marmot's report 'Health Equity in England' of bringing the level of health of deprived areas in the North up to the level of good health enjoyed by people in affluent areas in London and the South *in addition to* the DLUHC proposed "mission" regarding narrowing the gap in healthy life expectancy between areas where it is highest and lowest by 2030?
- **Local priorities:** How can national outcomes of the kind above be framed in ways that support rather than undermine local flexibility and autonomy in decision making and delivery? How should ICSs develop their own local health inequality priorities and targets at ICS, 'place' and Primary Care Network population levels?
- **Public Health:** How do ICSs ensure that their strategic public health role is supported financially including links to public information campaigns and social prescribing?
- **Shifting the curve:** What should ICSs prioritise to ensure they are successful in 'shifting the curve' on reducing health inequalities and improving the health of their population – how can CorePLUS5 be built upon?
- **Anchor institutions:** How can ICSs ensure large hospitals and providers in their area understand and implement their role as anchor institutions in the community to reduce inequality, improve population health outcomes and help drive regional economic development?

### Part Two: Developing ICS best practice and shared outcomes for children and young people's health, care and wellbeing

- **Steve Crocker**, President, the Association of Directors of Children's Services
- **Russell Viner**, Professor of Adolescent Health at the UCL Great Ormond Institute of Child Health
- **Rukshana Kapasi**, Director of Health, Barnardo's

### *Key Questions:*

- **Shared outcomes for children:** What shared outcomes should ICSs develop for children – e.g., reduced obesity levels and eating disorders, reduced mental distress and better mental health outcomes, and reduced waiting times and lists for care assessments and services?
- **Engaging young people:** How can ICSs co-produce shared outcomes and delivery mechanisms *with*, and not just for, children and young people to ensure action addresses what matters most to them?
- **Partnerships with schools:** How will schools and academies as key providers of services and influences on the lives of children and young people become partners in an ICS with health and children’s social care services, and public health services?
- **Integrated Children’s Policy Framework:** How should ICSs develop and implement a robust, integrated Children and Young People’s Health, Social Care and Education Framework to shape local provision?
- **National integration:** How should the Government “mirror”, in a meaningful way, local efforts to join up health, social care, public health and education at a national level?

### **Part Three: Developing ICS best practice in mental health services and support for people with learning disabilities**

- **David Weaver**, President, British Association for Counselling and Psychotherapy
- **Jackie O’Sullivan**, Director, and **Ciara Lawrence**, Big Plan Engagement Lead, Mencap
- **Claire Bruin**, Care and Health Improvement Adviser, LGA

### *Key Questions: Mental Health*

- **Legislation/Policy** What do ICCs wish to see in the draft Mental Health Act Reform Bill and the Government’s Ten Year Mental Health and Wellbeing Plan to provide the right framework within which they can fulfil their responsibilities and achieve their goals?
- **Recovery plan:** Should every ICS develop a post-Covid local mental health recovery plan as well as contributing to the development of a national mental health recovery plan as called for by the NHS Confederation and the Royal College of Psychiatrists?
- **Parity of esteem in funding:** What does parity of esteem in the funding of mental health services mean for an ICS given the range of providers across different sectors and the variety of their sources of funding, and how can it be achieved over time in each area?
- **Addressing existing gaps in provision:** How can ICSs develop complementary systems to address gaps in existing national mental health provision to urgently address unmet local need, particularly for people from Black and ethnic minority communities, older people and those who fall between the thresholds of different services; and how can they support the Third Sector in helping to meet local needs?
- **National benchmarks:** Should there be national benchmarks for mental health outcomes and services to reduce geographical inequalities; and how can these be framed to supports rather than undermine local flexibility and autonomy in decision making and delivery?
- **Shared mental health outcomes:** What should ICSs do to achieve greater integration of mental health, physical health and social care services such as creating shared mental health outcomes and ensuring they have required mental health insights and expertise to inform decisions?

## Key Questions: Learning Disabilities

- **Engaging people with learning disabilities and/or autism:** How can ICSs co-produce shared outcomes and delivery mechanisms *with*, and not just for, those with learning disabilities and/or autism to ensure action addresses what is most important to them?
- **Life expectancy:** What role should ICSs play in reducing the inequality in the life expectancy of people with learning disabilities, autism and both?
- **Access to services:** What role should ICSs play in reducing inequality in access to services for people with learning disabilities, autism and both such as access to cancer screening?
- **Integrated services:** How can ICSs help to integrate health and social care services for people with learning disabilities, autism and both, remove the barriers for getting good quality healthcare and develop a truly person-centred approach that moves away from a medical model of care?
- **Improvement standards:** What role should ICS play in making progress in the NHS learning disability improvement standards for health services and what standards should apply to them as organisations?

## 1 REDUCING HEALTH INEQUALITIES

### 1.1 *The Context*

Health inequalities are widening and worsening. The most recent report by Professor Michael Marmot '[Health Equity in England](#)' shows that since 2010 life expectancy in England has stalled; this has not happened since at least 1900. The health of the population is not just a matter of how well the health service is funded and functions, important as that is. Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.

Life expectancy follows the social gradient – the more deprived the area the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010-12 and 2016-18.

There are marked regional differences in life expectancy, particularly among people living in more deprived areas. Differences both within and between regions have tended to increase. For both men and women, the largest decreases in life expectancy were seen in the most deprived 10 percent of neighbourhoods in the north east and the largest increases in the least deprived 10 percent of neighbourhoods in London.

Mortality rates have increased for people aged 45-49 and it is likely that social and economic conditions have undermined health at these ages. People in more deprived areas spend more of their shorter lives in ill-health than those in less deprived areas. The amount of time people spend in poor health has increased across England since 2010. Inequalities in poor health harm individuals, families, communities and are expensive to the public purse.

‘Health Equity in England’ notes the success achieved by local government in areas such as Coventry and Greater Manchester to address health inequalities and goes on to make a number of detailed recommendations for action in six areas:

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.
2. Ensure proportionate universal allocation of resources and implementation of policies.
3. Early intervention to prevent health inequalities.
4. Develop the social determinants of health workforce.
5. Engage the public.
6. Develop whole systems monitoring and strengthen accountability for health inequalities.

A key obstacle to politician’s and the public’s engagement in this wider ‘social determinants’ agenda was highlighted in a recent report commissioned by the Health Foundation: [A Matter of Life and Death – Explaining the Wider Determinants of Health in the UK](#). This found that “dominant thinking about health is highly individualistic; health is thought to be the result of choices we make over what we eat, how often we exercise, and whether we have the willpower and discipline to stick to a healthy lifestyle. Health was also thought of simply as the absence of illness and the medical care we receive from the NHS. This dominant thinking obscures the impact of the wider determinants and the role they play in shaping health.”

## **1.2 The Commission’s view**

The Commission’s report ‘Levelling Up Health’ proposed that ICSs should promote a ‘health in all policies’ approach to encourage greater action by other public, voluntary and private sector organisations to improve population health and reduce health inequalities.

The Commission believes that ICSs should work collaboratively with local stakeholders across the public, private and VCSE sectors to address issues such as educational underachievement, poor housing, pollution, diet, smoking, unemployment, transport to access services, poverty, mental health inequalities, loneliness and isolation, health literacy and so on. It will be clearly necessary for ICSs to take local action together with partners to achieve jointly agreed shared outcomes.

The Commission also said that ICSs should adopt an ‘economic wellbeing’ approach in all its strategic decisions to improve the impact it has as an anchor institution in local communities. A conclusion from the Commission’s April meeting was recognising that work itself is a health outcome. In this way, ICSs can realise their potential to support the wellbeing of the community including, for example, in their choice of local suppliers, local employment policies, investment in local premises and buildings, and support for local facilities such as community green spaces and healthy town centres.

## **1.3 Government and NHSE Policy**

Given those aspirations, a major welcome feature of the new system described in detail in ‘**Joining up care**’ is the development of shared outcomes and ‘a new approach to setting shared priorities which is integrated and focuses on key outcomes which matter for people’s health and wellbeing and improve population health’.

The Commission believes this is a paradigm shift in our health care system away from a traditionally NHS-dominated, treatment-centred approach, to an accountable partnership of local organisations with a common purpose focused on delivering seamless person-centred care, improving the public's health and reducing health inequalities.

The Department for Levelling Up, Housing and Communities have also included a "mission" that is relevant to reducing health inequalities in its recent [White Paper](#). "By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will have risen by five years."

The Government also reference levelling up prominently in their policy agenda, including through programmes of investment targeting towns and cities considered in greatest need of economic regeneration. This is an important policy intention that ICSs be aware of and seek to build upon as they develop their wider remit to support social and economic development in their area.

Meanwhile NHS E&I's approach to support the reduction of health inequalities at both national and system level is outlined in its [Core20PLUS5](#) programme which defines a target population cohort for reducing health inequalities and five clinical areas requiring accelerated improvement that ICSs will need to address. These are:

- i) **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
- ii) **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
- iii) **Chronic respiratory disease:** a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
- iv) **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
- v) **Hypertension case-finding:** to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

#### **1.4 The role of hospitals in improving public health and reducing health inequalities**

The anchor role of hospitals in reducing health inequalities and supporting wellbeing and prosperity in the communities they serve is described in the [Shelford Group Strategy, 2021-2025](#). The Shelford Group is an NHS collaboration between ten of the largest health provider organisations in England who as major public sector organisations in the city-regions embrace their role as anchor institutions, working with public sector partners within and beyond the NHS to reduce inequality, improve population health outcomes and drive regional economic development.

One of the six strands of the Shelford Group Strategy is that of supporting 'Anchor Collaborations'. The concept of **anchor organisations** is described as having evolved in response to the challenge of improving population health outcomes and reducing deeply rooted inequalities. The role of NHS providers as anchors is seen as extending significantly beyond the diagnosis and treatment of ill health to address population health & inequality by influencing the wider determinants of health. Anchor organisations are defined in part by their purposeful undertaking of strategic and operational decisions which seek to affect these wider determinants. Their scale and the fact that they are tied to the place in which they are based are defining characteristics of an anchor.

Opportunities to effect wider determinants span the public policy spectrum and extend beyond the four walls of a hospital; partnerships are therefore an essential capability for an effective anchor organisation. Anchor collaborations describe the communities of organisations which can work together to amplify their anchor mission through collective action.

The Shelford Group recognises the potential for anchor collaborations to bind NHS, local government, charitable, university and commercial partners together in addressing common and synergistic priorities. These synergies are evident throughout their new strategy. Realising the potential of the NHS as an anchor is critical to long term delivery across all of our ambitions.

### **1.5 Going forward**

The Commission is seeking to promote a shared outcomes framework that is comprehensive in scope, includes health inequalities and economic wellbeing as well as service outcomes, adopts an all-age approach, and allows flexibility for the local partners in each place to set their own priorities for shared outcomes as well as delivering national shared outcomes set by the Government.

A limited number of nationally determined shared outcomes should focus on key aspects of reducing health inequalities and improving the public's health. Benchmarks or measures of success should be set by each ICS set that are relevant to different localities at ICS, place and neighbourhood level (and not just be a comparison with national averages).

Whilst the immediate pressures on commissioners and providers will be to tackle the backlog of treatments as highlighted in the 2021 Queen's Speech and unmet need resulting from the pandemic, it is crucial that system leaders start now to work together to develop local, relevant public health and health inequality shared outcomes, including racial inequalities, and underpinned by actions to support their achievement.

### **1.6 Key Questions**

- **Levelling up health:** Should the Government adopt the goal as proposed in Michael Marmot's report 'Health Equity in England' of bringing the level of health of deprived areas in the North up to the level of good health enjoyed by people in affluent areas in London and the South *in addition to* the DLUHC proposed "mission" regarding narrowing the gap in healthy life expectancy between areas where it is highest and lowest by 2030?
- **Local priorities:** How can national outcomes of the kind above be framed in ways that support rather than undermine local flexibility and autonomy in decision making and delivery? How should ICSs develop their own local health inequality priorities and targets at ICS, 'place' and Primary Care Network population levels?
- **Public Health:** How do ICSs ensure that their strategic public health role is supported financially including links to public information campaigns and social prescribing?
- **Shifting the curve:** What should ICSs prioritise to ensure they are successful in 'shifting the curve' on reducing health inequalities and improving the health of their population – how can CorePLUS5 be built upon?
- **Anchor institutions:** How can ICSs ensure large hospitals and providers in their area understand and implement their role as anchor institutions in the community to reduce inequality, improve population health outcomes and drive regional economic development?

## 2 SHARED OUTCOMES FOR THE HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE

### 2.1 *The context*

#### *a) Physical health*

Evidence shows that young people are increasingly exposed to two [new childhood epidemics](#) - obesity and mental distress - that require more than just a clinical response; and that progress in improving [the health of children under five has stalled](#) in the last five years – particularly infant mortality. Inequalities in [maternity care](#) are now a national health priority.

#### *b) Social care*

The ongoing Independent Review of Children’s Social Care has highlighted that demand for [children’s social care services](#) is rising. Meanwhile families are experiencing [serious delays for assessment and treatment](#) for children with special educational needs and disabilities including autism. The Government published on 29<sup>th</sup> March 2022 its SEND Review - [right support, right place, right time](#) – and invited responses. Meanwhile in some localities [30% of children are living in income-deprived families](#) and the cost of living increases this year will make this worse.

A [Council for Disabled Children analysis](#) identified a number of potential opportunities of ICSs for children with Special Educational Needs and Disability (SEND) including strengthening the roles of Designated Medical Officers (DMO) and Designated Clinical Officers (DCO) in the system governance, joint planning and whole system approaches to improving outcomes, service integration and collaboration at ‘place level’, social prescribing models for children through Primary care Networks, and a SEND performance dashboard at ICS level.

#### *c) Mental health*

The Children’s Commissioner’s report on the State of [Children’s Mental Health Services](#) in 2019/20 described access to children’s mental health services as still not adequate with only an estimated one in four accessing the services they need; and only 20% receiving the service within the Government’s 4-week waiting target. A particular concern is the postcode lottery of variation between geographical areas on service spending, waiting times, percentage accessing services, and the closure of cases before treatment has been provided.

The Commissioner says the ambition in the NHS 10-year plan - to provide support to all children who need specialist care by 2028 - now needs a clear delivery plan to ensure this target is met; and that this will only be achieved if the system of support on offer is broadened out to include support in schools, online and from the voluntary sector.

A central part of the [Government’s Green Paper](#) on children’s mental health services, published in 2018, is the implementation of ‘Mental Health Support Teams’ (MHSTs) to facilitate joint working between schools and the NHS, with graduated levels of support available across schools and specialist services. However, the Government committed only to reaching 20% of areas (with a maximum of 25%) within five years and as there are as yet no definite plans to roll-out the MHSTs to the other 75%-80% of the country. The Commissioner has called on the Government to commit to the implementation of MHSTs in every region.



A recent analysis of mental health demand by the NHS Confederation during Mental Health Awareness Week in May 2022 showed that providers have seen a significant increase in demand for mental health support alongside increased severity of cases. The trend was particularly notable in children and young people with eating disorders. The number of referrals of children and young people to services increased by around 77% compared to before the pandemic, with the numbers waiting for urgent support with an eating disorder 92% higher than the same time last year.

Early intervention for eating disorders, like any mental health condition, is key to ensuring that the illness does not become chronic and continue into adulthood as [50% of adult mental health problems start by the age of 15](#).

#### *d) Education*

Schools and academies have a vital role to play in the supporting the health and wellbeing of children and young people. Many now have social workers and health workers on site. The idea for example of every school being a healthy school is growing in importance – being a part of the school the curriculum, reflected in the school meals and snacks policy, providing personal support for vulnerable students, ensuring healthy inter-personal behaviour, and providing opportunities for play, sport and recreation.

The relationship between schools/academies and children’s social services and health care services for children and young is also key to an integrated approach to improving children’s health, care and wellbeing; and to their educational development and success.

The School’s Bill, announced in [the Queen’s Speech 2022](#), does not however mention children’s health or mental health although there is a reference to improving safeguarding and to “Enabling better, more targeted, and more consistent multi-agency support to the children and families who need it most across England by making necessary reforms to the attendance legal framework. The Bill will require schools to publish an attendance policy and will put attendance guidance on a statutory footing, making roles and responsibilities clearer.”

#### *e) An integrated approach*

Responsibility for improving health and wellbeing of children and young people is held by a number of statutory services including the NHS, Local Government children’s services, public health, schools and education, and other public services. Each of these services are “owned” by different Government Departments. Each “silo” has their own policies, outcomes frameworks, priorities, targets, structures and funding streams delivered by a range of providers with local priorities. Despite their inclusion in the [NHS Long Term Plan](#), the health and care needs of children and young people do not feature in the [Integration and Innovation White Paper](#) and were a late addition through Lords’ amendments to the [Health and Care Bill](#) currently before Parliament.

The Commission believes there is an emerging consensus that the challenge of reversing the decline in the health of children and young people, and meeting the growing demand for children’s social care, could be achieved through a new, place-based, integrated approach to children led by Integrated Care Systems.

There are international examples of new ways of working that could be drawn upon such as that in Sweden where they are able to keep children healthy and out of hospital, but when they do need to be admitted, avoid long waiting times and keep their average length of stay to 10 days - and a parent is able to accompany the child. Because the young person stays only a short time, they are able to help far more young people, far quicker with a smaller bed base, freeing up resources for earlier support in the community.

## **2.2 Government policy**

“Shared Outcomes” are at the heart of the Government’s [Integration White Paper](#) and will be a key driver for all Integrated Care Systems. Children’s services are within the scope of Integrated Care Systems and the White Paper says ‘places are encouraged to consider the integration between and within children and adult health and care services wherever possible’.

The [Health Devolution Commission](#), supported by Barnardo’s as well as the LGA, NHS Confederation and other partners, believes the creation of shared outcomes to improve the health and wellbeing of children and young people, supported by a robust, integrated children’s policy framework, would be a massive step forward.

Guidance on the role of ICSs regarding children and young people from NHSE/I and the DHSC is planned for July 2022 and is likely to include:

- Delegation of responsibility for SEND and safeguarding statutory duties to an ICB executive lead (in NHSE statutory guidance)
- Role of ICB children’s lead to champion children (in NHSE statutory guidance)
- ICPs’ strategies to consider child health and wellbeing outcomes and the integration of children’s services (in DHSC statutory guidance)
- ICPs to consult children’s system leaders, and children and families themselves, on the strategy (in DHSC statutory guidance)
- ICPs consider opportunities to further integrate family hub arrangements with health and social care services

## **2.3 Going forward**

One potential task for ICSs could be to develop and then implement a robust, integrated Children and Young People’s Health, Social Care and Education Framework, recognised and supported by the Government, to guide their planning, commissioning and assessment of their services.

The potential design principles for such a framework, that has shared outcomes for the health and wellbeing of children and young people at its heart could include:

- Be comprehensive in scope, embracing health, social care and education in a whole family approach
- Reflect the life-course of children and young people from birth to young adulthood
- Be rooted in the voice of children and young people
- Address children’s health and care inequalities as a priority
- Recognise the support needs of unpaid young carers in the home
- Identify clear priorities for action for each health, care and education service
- Specify the measures for assessing success and ensuring accountability

Drawing on the approach taken within other national strategies and policies it is possible to identify seven **domains** that might form the basis of an integrated health and care framework for children:

1. **Shared outcomes** across health, social care and schools, e.g., reducing infant mortality, children's health inequalities and youth unemployment
2. **Physical health outcomes**, e.g., improving long term conditions, such as asthma and diabetes, and reductions in unnecessary use of A&E
3. **Mental health outcomes**, including improved community services for families and reduction in youth suicides
4. **Public health, prevention and early intervention outcomes**, e.g. preventing injury and increasing healthy behaviour
5. **Social care and family outcomes** such as levelling up the assessments and services for children with disabilities between localities and all inequalities
6. **School outcomes**, e.g., improved school readiness, every school a healthy school, and improved support for special educational needs
7. **Organisational outcomes** including a strong voice for children and young people within ICSs, a single CYP accountable officer, and a more integrated child health and social care workforce

The Commission considers the development of shared children's health and care outcomes underpinned by a robust policy framework to be a unique opportunity for ICSs. It will take time and long-term commitment to deliver, including building the necessary relationships and joint working across the local "silos", not least with schools and academies. But this approach offers the most realistic opportunity to reverse the [rates of children's health across England](#) to become above, not below, the average found across the European Union as they are today.

## 2.4 Key Questions

- **Shared outcomes for children:** What shared outcomes should ICSs develop for children – e.g., reduced obesity levels and eating disorders, reduced mental distress and better mental health outcomes, and reduced waiting times and lists for care assessments and services?
- **Engaging young people:** How can ICSs co-produce shared outcomes and delivery mechanisms *with*, and not just for, children and young people to ensure action addresses what matters most to them?
- **Partnerships with schools:** How will schools and academies as key providers of services and influences on the lives of children and young people become partners in an ICS with health and children's social care services, and public health services?
- **Integrated Children's Policy Framework:** How should ICSs develop and implement a robust, integrated Children and Young People's Health, Social Care and Education Framework to shape local provision?
- **National integration:** How should the Government "mirror", in a meaningful way, local efforts to join up health, social care, public health and education at a national level?

### **3 IMPROVING MENTAL HEALTH SERVICES**

#### **3.1 Context**

A 2021 House of Commons Library research paper [‘Mental Health Statistics’](#) says that 1 in 6 adults have experienced a common mental disorder (CMD) like depression or anxiety in the last week; and that 1 in 6 children aged 6 to 16 had at least one probable mental health problem in 2021, up from 1 in 9 in 2017.

Common Mental Disorders have become more widespread since 1993 and prevalence has risen by around one-fifth in both men and women. Economically inactive and unemployed people are substantially more likely to have experienced a CMD in the last week than those who are in work.

Prevalence of CMDs varies by ethnicity, with those identifying as Black more likely than average to have experienced a CMD in the last week, and with non-British people identifying as White less likely. The report [‘Race for the Soul of the profession’](#) published by the BACP in May 2022, analyses the deep-seated and longstanding racial inequalities inherent within our mental health system.

There is a serious concern that, following the Covid-19 pandemic, there is now a [‘second pandemic’](#) of depression, anxiety, psychosis and eating disorders; and long waiting lists for treatment including [up to 18 months for people in crisis](#). In some parts of the country, specialist mental health services are said to be so overwhelmed they are “bouncing back” even the most serious cases of patients at risk of suicide, self-harm and starvation to the GPs that referred them, prompting warnings from doctors that some patients will likely die as a result.

The NHS Confederation is calling for an expansion of NHS estates for specialist mental health care, and a major recruitment drive, as part of a recovery plan. One in 10 consultant psychiatrist posts are unfilled. The Royal College of Psychiatrists believes a fully funded mental health recovery plan, backed by a long-term workforce plan, is needed to ensure everyone with a mental illness can get the help they need when they need it.

#### **3.2 The Commission’s view**

The Commission believes there should be parity of esteem in ICS investment in physical and mental health to address mental health inequalities, many of which have been exacerbated during the Covid-19 pandemic. It has also recommended that mental health is fully represented on the ICS Board and ICS Partnership as well playing a major role in place-based partnerships and neighbourhood networks.

The Commission’s original report identified concerns among some mental health stakeholders that health devolution could exacerbate local variation in the quality of mental health services particularly if there is poor local leadership. The fear is that some ICSs may not rise to the challenge of delivering better mental health services in their area as this will require prioritising mental health, expanding the workforce, working in partnership with LAs and engaging with the third sector.

### **3.3 Government Policy**

'Joining up care' sets out the government's ambition for better integration across primary care, community health, adult social care, acute, **mental health**, public health and housing services which relate to health and social care.

The [2022 Queen's Speech](#) includes a commitment to publish a draft Mental Health Act Reform Bill whose purpose is two-fold, to:

- Ensure patients suffering from mental health conditions have greater control over their treatment and receive the dignity and respect they deserve.
- Make it easier for people with learning disabilities and autism to be discharged from hospital.

The main benefit of the Bill is described as modernising the Act so that it is fit for the 21st century and provides a framework for services in which people experiencing the most serious mental health conditions can receive more personalised care, with more choice and influence over their treatment and a greater focus on recovery. Specific benefits are described as:

- Helping to address the existing disparities in the use of the Act for people from ethnic minority backgrounds – especially for detentions and for the use of Community Treatment Orders.
- Ensuring that detentions only happen where strictly necessary.
- Improving how we support offenders with acute mental health needs, ensuring they have access to the right treatment, in the right setting, at the right time – with faster transfers from prison to hospital, and new powers to discharge patients into the community while ensuring the public is protected.

The government has also committed to develop a new cross-government, [10-year plan for mental health and wellbeing for England](#) to improve mental health and wellbeing outcomes, particularly for people who experience worse outcomes than the general population. This is described as a key part of their commitment to 'level up', and address unequal outcomes and life chances across the country.

### **3.4 Going forward**

The draft Mental Health Act Reform Bill and the 10-year plan for mental health and wellbeing provide an opportunity for ICS leaders to influence the policy framework within which they will fulfil their responsibilities for improving and integrating mental health services with physical health and social care services.

The proposal for the development of a national mental health recovery plan as we emerge from this current phase of the Covid-19 pandemic also provides an opportunity for ICS system leaders across health and social care to collectively influence national policy, and to develop such a plan for their individual ICS. However, the challenge of achieving parity of esteem for the funding of mental health services remains and is a matter for national government to address as well as a goal to be achieved over time by all ICSs.

### 3.5 Key Questions

- **Legislation/Policy:** What do ICCs wish to see in the draft Mental Health Act Reform Bill and the [Government's Ten Year Mental Health and Wellbeing Plan](#) to provide the right framework within which they can fulfil their responsibilities and achieve their goals?
- **Recovery plan:** Should every ICS develop a post-Covid local mental health recovery plan as well as contributing to the development of a national mental health recovery plan as called for by the NHS Confederation and the Royal College of Psychiatrists?
- **Parity of esteem in funding:** What does parity of esteem in the funding of mental health services mean for an ICS given the range of providers across different sectors and the variety of their sources of funding, and how can it be achieved over time in each area?
- **Addressing existing gaps in provision:** How can ICSs develop complementary systems to address gaps in existing national mental health provision to urgently address unmet local need, particularly for people from Black and ethnic minority communities, older people and those who fall between the thresholds of different services; and how can they support the Third Sector in helping to meet local needs?
- **National benchmarks:** Should there be national benchmarks for mental health outcomes and services to reduce geographical inequalities; and how can these be framed to support rather than undermine local flexibility and autonomy in decision making and delivery?
- **Shared mental health outcomes:** What should ICSs do to achieve greater integration of mental health, physical health and social care services such as creating shared mental health outcomes and ensuring they have required mental health insights and expertise to inform decisions?

## 4 SUPPORTING PEOPLE WITH LEARNING DISABILITIES

### 4.1 Context

[An analysis by the LGA and ADASS](#) says that around 1.04 million people aged 15 to 64 in England have learning disabilities or autism or learning disabilities **and** autism. This group experience disproportionate levels of inequality and their quality of life outcomes are lower than it is reasonable to expect in the 21st century.

The joint outcomes and improvement framework for adults with learning disability and/or autism has six elements:

- **Inclusion:** Support people to have good lives in their communities and to be treated with dignity and respect.
- **Equal access:** To opportunities and services e.g. contributing to community life, social and leisure opportunities, housing, banking, jobs, health, and transport.
- **Person centred planning and support:** Involve people, families, and carers in solutions that respond to the individual strengths and needs.
- **Safeguarding:** Be safe in communities and free from the risk of discrimination, hate crime and abuse.
- **Sustainable models of support:** A commitment to focus on developing these.
- **Progression:** Recognising that people with disabilities (including the most complex) have the potential to progress and develop.

[An analysis by Mencap](#) shows that people with a learning disability have worse health than people without a learning disability and are more likely to experience multiple health conditions. On average, the life expectancy of women with a learning disability is **27 years shorter** than for women in the general population. The life expectancy of men with a learning disability is **23 years shorter** than for men in the general population (NHS Digital 2017).

The [Confidential Inquiry](#) into premature deaths of people with a learning disability also found that 38% of people with a learning disability died from an avoidable cause, compared to 9% in a comparison population of people without a learning disability. There are 1,200 avoidable deaths every year. It is also notable that in 2017/18, around half (52.5%) of women with a learning disability had been screened for breast cancer, compared to 68% of women without a learning disability. Meanwhile, less than a third (31.2%) of eligible women with a learning disability had received cervical smear tests, in contrast to 73.2% of women with no learning disability.

The rate of dementia is high in all people with a learning disability, but is particularly high in people with Down's syndrome. In 2017/18, the prevalence rate for people with a learning disability aged 55-64 was 4.3%, compared to 0.3% of those with no learning disability. For ages 65-74 it was 5.9% for people with a learning disability, compared to 1.1% for those without. For those aged 75 and over it was 11.2% for people with a learning disability, compared to 8.7% for those without.

Common associated health conditions for people with a learning disability include mental health problems, epilepsy, and being underweight or overweight.

A number of barriers are stopping people with a learning disability from getting good quality healthcare including:

- a lack of accessible transport links
- patients not being identified as having a learning disability
- staff having little understanding about learning disability
- failure to recognise that a person with a learning disability is unwell
- failure to make a correct diagnosis
- anxiety or a lack of confidence for people with a learning disability
- lack of joint working from different care providers
- not enough involvement allowed from carers
- inadequate aftercare or follow-up care

#### **4.2 NHS/Government policy**

[The NHS](#) recognises that it has a crucial role to play in helping people with a learning disability, autism or both to lead longer, happier and healthier lives. [The NHS Long Term Plan](#) aims to improve people's health by making sure they receive timely and appropriate health checks, while improving the level of awareness and understanding across the NHS of how best to support them as patients.

The NHS aims to ensure that more people with complex needs will be supported to live fulfilling lives at home rather than in hospital, while thousands will be offered a personal health budget, giving them choice over the type of support they need to live the life they choose. It will:



- Improve community-based support so that people can lead lives of their choosing in homes not hospitals; further reducing our reliance on specialist hospitals, and strengthening our focus on children and young people
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access to, experience of and outcomes from care and treatment
- Reduce health inequalities, improving uptake of annual health checks, reducing over-medication through the Stopping The Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR)
- Continue to champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability and of autistic people
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.

In particular, ICSs will be expected by the NHS to make sure all local healthcare providers are making reasonable adjustments to support people with a learning disability or autism.

An example provided by the NHS of integration is 'The Ealing Intensive Therapeutic and Short Breaks Service' that supports children, young people and their families so that they don't need to go into hospital. To make this work health, mental health, social care and education services are all in one building where they work together to do what is needed so that children and young people with a learning disability can stay living at home when they need extra support or treatment.

The Health and Care Act 2022 now requires ICSs to nominate a member of the Integrated Care Board of the ICS to be the lead for learning disabilities and autism.

An [analysis by Mencap](#) in 2022, however, shows that too many adults with a learning disability are still being held in inpatient units rather than supported to lead independent lives in the community as envisaged by the Government's Transforming Care Strategy:

- There are at least 2,005 people with a learning disability and/or autism in inpatient units.
- In January 2020 alone there were 3,570 reported uses of restrictive interventions e.g., physical, chemical, mechanical restraint and being kept in isolation
- The average length of stay for people with a learning disability and/or autism who are currently in inpatient units is 5.6 years
- The number of children with a learning disability and/or autism in inpatient units has increased since the start of the Transforming Care programme.



### 4.3 Going forward

The NHS has developed new [learning disability improvement standards](#) to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both. The four standards will be applied to all NHS-funded care by 2023/24 and concern:

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

[An NHS report in 2019](#) described the performance of the NHS against these learning disability improvements standards and now provides a baseline against which systems can assess their performance.

ICSs are in a unique position not just to improve the experience of health services and health outcomes of people with a learning disability but to go further and, through integrating health and social care support, to move away from a medical model of care to a truly person-centred model. This may represent a significant culture shift for the NHS as it is about going further than meeting a medical need and enabling people with a learning disability to live independent lives with support in the community.

### 4.4 Key Questions

- **Engaging people with learning disabilities and/or autism:** How can ICSs co-produce shared outcomes and delivery mechanisms *with*, and not just for, those with learning disabilities and/or autism to ensure action addresses what is most important to them?
- **Life expectancy:** What role should ICSs play in reducing the inequality in the life expectancy of people with learning disabilities, autism and both?
- **Access to services:** What role should ICSs play in reducing inequality in access to services for people with learning disabilities, autism and both such as access to cancer screening?
- **Integrated services:** How can ICSs help to integrate health and social care services for people with learning disabilities, autism and both, remove the barriers for getting good quality healthcare and develop a truly person-centred approach that moves away from a medical model of care?
- **Improvement standards:** What role should ICS play in making progress in the NHS learning disability improvement standards for health services and what standards should apply to them as organisations?

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