Artwork from the National Art Exhibitions of the Mentally Ill, Inc (NAEMI), an organization dedicated to discovering and preserving the art of people with mental illness.

Current Trends in Schizophrenia Services:

Opportunities to Improve Care

Date of preparation: December 2018
Job code: PHGB/NPR/1118/0029

janssen

CONTENTS

INTRODUCTION

Who is this report for?

This report is designed to be a resource for NHS policy and decision-makers with responsibility for commissioning and delivering or scrutinising the delivery of services to people with the serious mental illness, schizophrenia.

A greater focus on mental health and better resource-use data is enabling closer examination of all aspects of the care pathway and has triggered an increase in investment aimed at driving improvements and innovation (Fig. 1). However, outdated commissioning practices, particularly the use of block contracts, are stifling progress and innovation in this area and preventing real, system-wide improvement. As a result, mental healthcare continues to lack parity with physical healthcare both in the treatment of individuals and the way in which care is organised and funded.

This report shines a light on the cost and consequence of current NHS commissioning practices. It aims to provide 'challenge' to consider how practice can be adapted to meet the rigours of significantly improving care while delivering NHS system efficiencies.

About Janssen

This report has been funded by Janssen Pharmaceuticals.

Janssen has a strong heritage in mental health with over 50 years of research leading to the development of innovative medicines to treat schizophrenia, schizoaffective disorder and bipolar disorder. With a focus on the well-being of patients and their families, Janssen is dedicated to improving access to education, support and treatment and works closely with a number of patient organisations to support activities and initiatives to achieve these aims.

For more information visit http://www.janssen.com/sustainability/mental-health

Fig. 1 The mental health policy environment

January 2016 – Then Prime Minister David Cameron announces extra £1 billion funding for mental healthcare by 2021 to support the delivery of the NHS Five Year Forward View for Mental Health[1]

February 2016 – Publication of the Five Year Forward View for Mental Health [2]

'The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services.'

May 2016 – The 2017/18 National Tariff introduces two new payment systems linked to achieving quality and outcome measures[3]

September 2016 – The Mental Health Investment Standard (MHIS) introduced in the NHS Operational Planning and Contracting Guidance.[4] The MHIS requires CCGs to increase spending on mental health by at least the same amount as their overall annual budget increases.

January 2017 – Prime Minister, Theresa May announces an extra £15 million for community mental healthcare: 'I want us to employ the power of government as a force for good to transform the way we deal with mental health problems right across society, and at every stage of life.'[5]

May 2018 – Government announces £15 million boost for local mental health crisis services 'The last place anyone experiencing a mental health crisis should be is in a busy A&E department let alone a police cell'.[5]

June 2018 – Government announces £20 billion funding boost for the NHS' 70th anniversary [7]

One of the key priorities is stated as: better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health.

October 2018 – The Chancellor announces in his budget speech that mental health services will receive a £2bn per year boost as part of the Government's package for the NHS[8]

EXECUTIVE SUMMARY

The UK's mental health sector is under considerable pressure and needs greater support to achieve the parity of esteem with physical health that the Government has committed to. Despite increased investment and initiatives to reform the commissioning environment, funding is still slow to reach frontline services.

- Data from the NHS Mental Health Dashboard shows that in 2017/18 more than one in ten CCGs failed to meet the Mental Health Investment Standard (MHIS) requirement to increase mental health funding in line with annual CCG budget increases[9].
- Whilst the Mental Health Dashboard monitors achievement of the MHIS, it provides no transparency in where this money is spent and whether it is reaching the right places to improve local outcomes.[10,11] In addition, it provides no data on block contract use and this lack of accountability means there is little impetus for commissioners to change practice.[12]
- Mental health care cluster data can help identify local population needs and inform service design and payment approaches. However, not all trusts are clustering patients appropriately and the proportion of patients who are being allocated a care cluster in a single year has never reached the 50% mark.[13]
- The limitations with clustering data plus the lack of consistency in CCGs financial reporting and difficulties in extracting specific service costs from block contracts have a negative impact on the quality and accuracy of the mental health dashboard data.[10,13]

The Five Year Forward View set out the need to adopt outcomes based commissioning models but it is clear that better data and support is needed to facilitate a move away from systems that are not delivering for patients in the best way possible and do not incentivise innovation.

The effects of this are starkly apparent in the provision of care for people with schizophrenia; one of the most debilitating and challenging mental illnesses. Most people with schizophrenia will require a lifetime of treatment, ranging from care through local community mental health teams to more intensive periods of support as a hospital inpatient. Fixed contractual arrangements are one of the key factors impacting on patients' access to local, timely care, appropriate to their needs, resulting in delayed hospital discharge for some whilst others are treated far from home due to bed shortages.

An accelerated move away from contracts which are unaccountable (block contracts) and embracing new and more effective commissioning systems will help the NHS eliminate many entrenched practises and long-term, issues that have dogged the mental health sector and prevented it from delivering effective, high quality care for those that need it. Better-quality data would enable the system to measure progress and accountability, to support improvements in care; particularly for people with schizophrenia.

CALL TO ACTION

Mental health needs more funding if it is to achieve parity of esteem with physical health. In addition, better data is also needed to reduce the variation in care that patients receive. Data around commissioning of mental healthcare can improve measurement and enable effective management of performance against outcomes. This report recommends:

1. A review of mental health clustering to better reflect care pathways, increase usability, improve data collection and drive increased use.
2. Revising the Mental Health Dashboard to include:
   a. Improved information and advice to ensure greater consistency in reporting
   b. Data on the use and monetary value of block contracts
   c. Increased granularity and additional spending metrics on readmission and relapse
   d. Operational performance data for people treated in secondary care and community care under a mental health trust
   e. Outcomes data
   f. Service user and carer experience data
3. Increased access to resources and templates to support the move to new models of commissioning services and dissemination of examples of alternative, outcomes-based commissioning models.
4. Incentivised commissioning to promote uptake of quality and outcomes-based service design, for example linking outcomes to NICE guidelines and quality standards for consistent delivery and reduced variation.

CHAPTER 1:

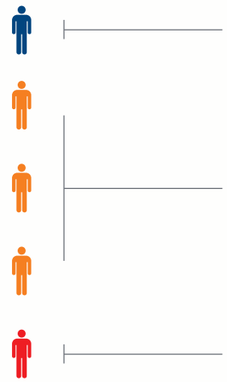
WHAT IS SCHIZOPHRENIA AND HOW DOES IT AFFECT PEOPLE?

Schizophrenia is a serious and challenging mental illness that has a considerable impact on the physical as well as mental health and wellbeing of people living with the condition and their carers.

Prevalence

- Schizophrenia affects approximately 1% of the population at some point in their life.[15]
- Some people may recover from an initial episode but for most, schizophrenia is a chronic illness which may worsen or improve in cycles known as relapse and remission.

For every five people with schizophrenia:



1 will get better within five years of their first obvious symptoms

3 will get better, but will have times when they get worse again

1 will have troublesome symptoms for long period of time[14]

Symptoms

- The cause of schizophrenia is unknown but a combination of physical, genetic, psychological and environmental factors are thought to make people more likely to develop the condition.[16]
- Symptoms are known as 'positive' – experiencing things that are not real e.g. hallucinations and delusions and 'negative' – lack of interest and motivation, changes in body language and reduced communication.[15]

General health and wellbeing

Medication, lifestyle factors and poor access to healthcare all contribute to an increase in physical ill-health meaning that compared to the general population people with schizophrenia are: [17]

- Likely to die up to 25 years earlier.[18]
- Twice as likely to die of heart disease.[17]
- Two to three times more likely to have type 2 diabetes.[17]
- More likely to have respiratory disease.[19]
- Three times more likely to die if they develop cancer.[17]
- More likely to attempt suicide.[20]

Care givers

Schizophrenia also places a considerable burden on family and informal carers:

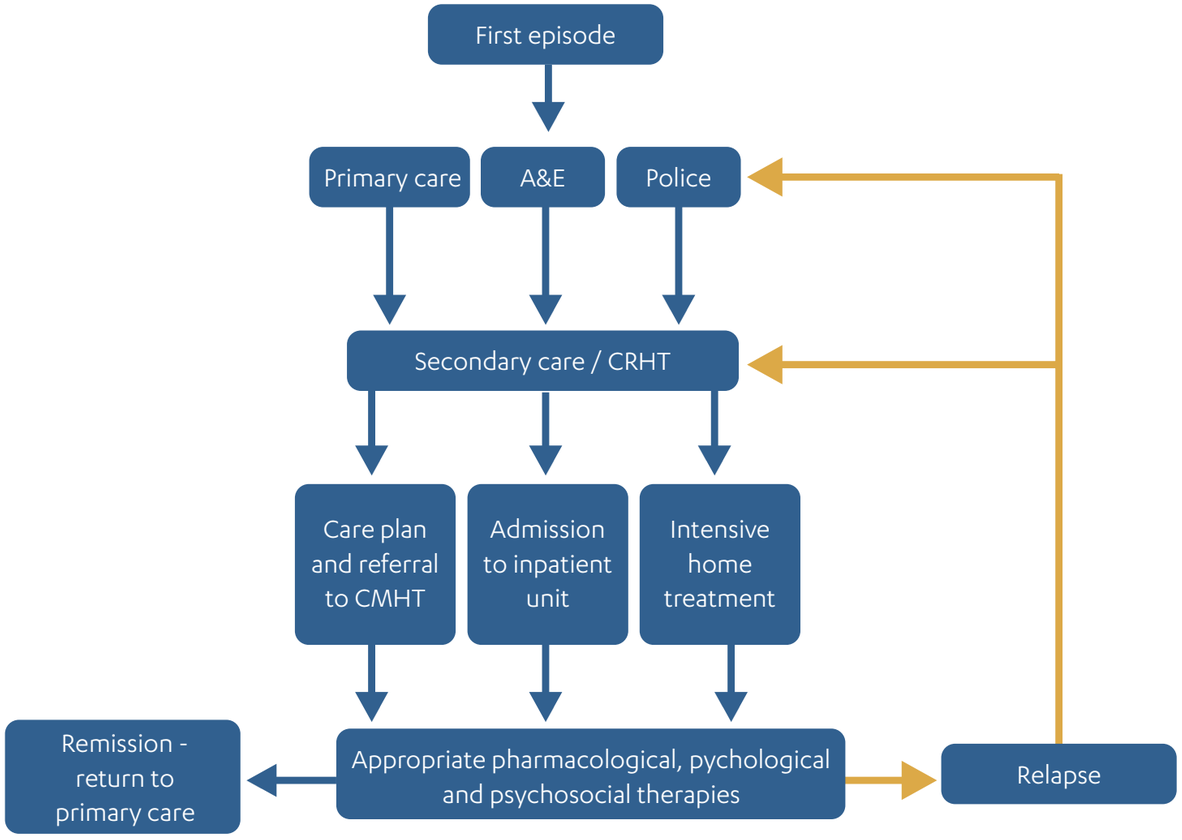
- Around 36% of schizophrenia care givers report that their health had become worse since starting caregiving. They are more likely to experience sleep difficulties, insomnia, pain, headaches, heartburn, anxiety and depression compared to non-caregivers.[21]
- A similar percentage believe that caring for someone with schizophrenia has disrupted their schedules; they are more tired, have difficulty relaxing and are not able to visit friends and family as often.[21]

CHAPTER 2:
HOW ARE PEOPLE WITH SCHIZOPHRENIA CARED FOR?

Treatment of schizophrenia requires a highly individualised approach with a package of medication, psychotherapy and psychosocial therapy tailored to meet specific patient needs.

Care for people with schizophrenia should be provided in the least restrictive environment possible, close to home and the individual's support networks.

Fig. 2 A simplified schizophrenia patient pathway



The goals of schizophrenia treatment are to support people in managing their symptoms, prevent relapse and promote recovery.

As symptoms of schizophrenia vary from person to person, care packages should be tailored around an individual's needs and include a combination of medication, psychotherapy and psychosocial treatments such as cognitive behavioural therapy (CBT) and family therapy. A simplified version of the pathway people with schizophrenia may follow through the NHS system is shown above (Fig. 2). On average, people with schizophrenia have 36.4 contacts with a healthcare professional each year.[13]

Practice has shown that people respond better to treatment when they are involved in decisions about their care[22] and care is provided in the least restrictive environment possible, close to home and patients' support networks.[23] Over recent years, this has prompted a shift in practice, aiming to ensure that most people are cared for by their community mental health team (CMHT), a local, specialist, multidisciplinary team that delivers day-to-day support and treatment around patient's health and social care needs.[24]

Provision of care for people in crisis is more intensive and usually provided by a Crisis Resolution (CR) Team or Crisis Resolution and Home Treatment (CRHT) team that is tasked with providing 24 hour, urgent care, outside of hospital, for people at risk of admission.[24] More serious acute schizophrenia episodes may require admission to a psychiatric ward at a hospital or clinic.[24] Accident and Emergency (A&E) departments are also seeing an increasing number of people with mental illness who require crisis support and treatment.[25,26]

CHAPTER 3:
THE FINANCIAL IMPACT OF SCHIZOPHRENIA

Despite its low prevalence, schizophrenia places a significant financial burden on both individuals and the economy.

Financial pressures on the NHS are growing as a result of increasing numbers of people with schizophrenia and challenges within the provision of mental health services that are driving high admission costs and straining emergency services.

Personal finance

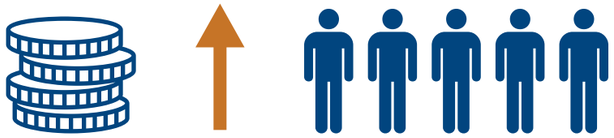
The personal financial burden of schizophrenia is considerable. Low employment rates result in the array of personal issues associated with life on a low income and caregivers can also be significantly financially impacted. There are also considerable broader societal costs.

It is estimated that each year in England schizophrenia accrues:[27]

- **£11.8 billion** societal costs and **£7.2 billion** public sector costs, the equivalent of **£96,000** combined total costs per person with schizophrenia. [27]
- **£1.24 billion** worth of unpaid care from family members or other unpaid carers. [27]
- **£3.4 billion** or the equivalent of **£17,200** per person with schizophrenia in lost productivity due to unemployment. [27]
- **£470 million** or the equivalent of **£3,600** per person with schizophrenia in benefits. [27]

Financial impact on the NHS

Schizophrenia and psychosis cost the NHS £2 billion in 2012/13, a figure that is expected to increase with rising patient numbers.[28]



Several factors impact on the high cost of schizophrenia care.

Rising patient numbers

The need for mental health services is increasing, with 1,400 more people accessing mental health services every day compared to 2010[29] and a dramatic rise predicted in the numbers of people experiencing schizophrenia spectrum disorders.[30]

Relapse

The cost of schizophrenia care is mainly driven by relapse or mental health crisis[31] – a recurrence of symptoms that may occur repeatedly throughout a lifetime.

- £205.4 million – the cost of psychotic crisis to the NHS[28]
- £1.1 billion – the cost of all expenditure related to recurrent psychosis (relapse) [28]

In-patient care

Schizophrenia accounts for the second highest number of total bed days of admitted patient care compared to any other diagnosis, including physical health diagnoses, with approximately 2.5 million bed days in 2016/17. [32]

- Costs increase with complexity of care. Current figures estimate that 20% of people with schizophrenia are in some type of admitted care.[17]
- The unpredictable nature of relapse means most inpatient care is unscheduled: in 2016/17 68% of schizophrenia admissions were non-elective and 32% elective with an estimated total cost to the NHS of £629 million.[13]
- In 2016/17 the mean length of stay for people with a primary diagnosis of schizophrenia was 52 days for non-elective admissions and 127 for elective admissions.[13]

High A&E attendances

Due to variable availability of appropriate crisis care around the country, increasing numbers of people with serious mental health needs, requiring urgent care are calling 999 or presenting at A&E.

- 175,082 A&E attendances for psychiatric problems in 2016/17 a rise of 55% since 2011-12.[25,26]
- 96,961 A&E attendances for people with a specific diagnosis of schizophrenia in 2016/17 costing the NHS an estimated £13.38 million.[13,33]
- 172,799 people with mental ill health who were in crisis, were assisted by paramedic in 2016/17, a rise of 23% on 2014/5 figures. They spent a total of 55,000 hours providing support – 32% more than the previous year.[34]

CHAPTER 4:
CHALLENGES IN DELIVERING SCHIZOPHRENIA CARE

The scale and pace at which change is being driven coupled with an increasing demand from a growing number of services users is placing considerable strain on mental health services.

Mental healthcare providers are faced with a complex range of challenges in delivering high quality, consistent care, leading to wide variation in availability of services across the country.

'I've experienced inadequate treatment many different times. Once I had a bad psychotic episode, and thought I had to set myself on fire to save the world. I went to A&E because I was scared that I couldn't keep myself safe. They said they had no capacity to help me, but that they would send the crisis team in morning. But I was in crisis there and then, and the morning was far too late – I was lucky that I didn't manage to hurt myself badly that night.'

Lack of parity with physical health

*Mental health accounts for **28%** of the demand on the NHS but only **13%** of its total CCG budget[35.36]*

The Health and Social Care Act 2012 stipulated that mental and physical health must be given equal parity.[37] However, stigma and prejudice continue to prevent mental ill health from being given the same importance as physical illness.

- 95% of people with physical health problems have a first outpatient consultation within 18 weeks of referral by their GP; only 74% of people with mental illnesses are seen in this time.[38]
- Referral to psychological therapies varied between 6 to 124 days for patients in 2014/15.[2]
- Only 45% of urgent mental health referrals are seen in a day, 15% wait more than 4 days.[39]

Provision of crisis and emergency care

*Less than **50%** of community teams offer an adequate 24/7 crisis service[2]*

Against a backdrop of financial austerity, many providers struggle to provide comprehensive crisis and emergency care; teams are under-resourced affecting their ability to respond to patient needs and there is considerable variation in the provision of services across the UK.[40]

- The number of referrals to crisis teams has risen dramatically in recent years whilst funding has decreased; 70% of trusts saw an increase in referrals and over a third of these had to reduce spending on their crisis teams between 2015 and 2016.[41]
- Liaison psychiatry services in acute settings are also struggling, with 61% of hospitals failing to provide an adequate 24 hour service.[42] With the deadline to achieve 100% of hospitals meeting the minimum level of service provision set as 2028/29, there is unlikely to be any rapid improvement in this area.[43]
- 32% of people with mental illnesses do not know who to contact in a crisis out of hours.[44]
- Only 14% of people who have experienced a crisis felt they received appropriate care that helped to resolve their crisis.[40]

Availability of core community services

*People wait an average of **14 weeks**, with no support, before being assessed by core community services such as CMHTs[45]*

Core community services are struggling to provide the ongoing support required by people severely affected by mental illness, leading to more people reaching crisis point, attending A&E or being detained under the Mental Health Act.[43] A recent survey by Rethink Mental Illness determined that:

- Over 25% of people felt that they had not been referred to an appropriate mental health service by their GP.[45]
- Following referral, people waited an average of 14 weeks to be assessed, with no support in the meantime and almost 10% waited six months or more.[45]

Shortage of inpatient beds

*Average occupancy in acute adult psychiatric wards is over **100%** with most wards operating above the Royal College of Psychiatrists recommended **85%** occupancy rate[23]*

Bed availability is co-dependent on numerous other factors in the mental health system such as availability and efficacy of community services and the length of time it takes for patients to be seen or discharged to other services. A recent survey of acute adult psychiatric wards found:

- Only 28% of consultants in charge of acute adult wards believe that there are enough inpatient beds.[23]
- 28% said that there would be enough beds if improvements were made to other services.[23]
- 16% of inpatient bed occupants could have been treated in other services if they had been available.[23]

Out-of-area placements (OAPs)

Between 2014/15 and 2016/17 ***79%*** *of Mental Health Trusts increased their number of OAPs, some by as much as eight times*[36]

Delays in accessing community services, a shortage of in-patient beds and poor availability of crisis and emergency care has contributed to increasing numbers of people with serious mental health needs being sent out of area to receive appropriate care.

- 79% of trusts increased their OAPs from 2014/15 to 2016/17[36] despite the Mental Health Taskforce's recommendation that inappropriate use of OAPs for adults in acute care should be eliminated by 2020/21.[2]
- The total recorded cost of OAPs for patients in crisis or ongoing/recurrent psychoses in 2017 was £54.3 million.[13]
- 95% of OAPs in May 2018 were due to unavailability of beds.[46]
- 25% of OAPs in May 2018 were between 50km and 100km from patient's homes, 36% were 100km or more.[46]
- Recovery time with the use of OAPs can be longer, increasing the risk of patients becoming institutionalised and the possibility of losing jobs, accommodation and benefits.[23,47]

Use of the Mental Health Act

Use of the Mental Health Act is at its highest point since record keeping began with the suggestion that this is being used as a mechanism to secure care placements

- There were 45,864 new detentions under the Mental Health Act in 2016/17, estimated to have increased 2% on the previous year's figures.[48]
- 37% of junior doctors working in psychiatry said that a colleague had used the Mental Health Act to detain a person, knowing it might make provision of a bed more likely.[49]

Staff shortages

The NHS loses over ***10,000*** *mental health staff each year*[50]

Mental health care has historically faced difficulties with staffing levels and recruitment.[46] Nursing numbers in particular have declined,[48] impacting on the availability of services and the delivery of effective, quality care for people with mental illnesses.

- The number of full-time equivalent mental health nurses fell by 13% between September 2009 and August 2017.[51]
- Requests for agency staff hours more than doubled from 930,000 in April 2012 to 1,917,000 in January 2015.[52]

CHAPTER 5:

FUNDING MENTAL HEALTHCARE AND THE IMPACT OF BLOCK CONTRACTING

Mental health lags behind physical health in the way in which services are organised and funded. To achieve true parity for mental health, service design and commissioning must be brought up to date with the same advances and innovations that have encouraged the uptake of new funding mechanisms and treatments in physical healthcare.

How is mental healthcare funded?

The majority of mental health services are delivered by mental health trusts with hospital and specialist establishments providing acute and specialist services respectively. Unlike most acute NHS services, which are commissioned using the National Tariff Payment System (NTPS) the majority of mental health services are commissioned by CCGs, through block contracts.

Block contracts provide a set payment for the delivery of a service over a given period of time. The payment is often made annually and is independent of the number of people treated or amount of activity undertaken.[53] As such there is poor financial transparency and little impetus to innovate or adapt services to improve quality and outcomes.

In an attempt to bring mental health commissioning in line with the rest of the NHS, mental health clusters were mandated for use from April 2012.[54] Each cluster groups people with similar mental health needs and is associated with a relevant package of care. The cost of each package of care then forms the currency that is the basis of contracting arrangements between commissioners and providers. Whilst this system has provided a better indication of needs, it has been criticised for not effectively mapping diagnosis and failing to incentivise outcomes.[2] Clustering also varies considerably between trusts and figures indicate that the proportion of patients who are being allocated a care cluster in a single year has never reached the 50% mark.[13]

To move towards parity of esteem between all health services, the NHS is supporting providers and commissioners of mental health services to implement more transparent, outcomes based payment models.[3] Two new payment systems linked to quality and outcomes were introduced from 2016/17:

- Episodic payment systems - based on a fixed payment for a period of care each person receives whilst assigned to a specific mental healthcare cluster.[3]
- Capitation based systems - linked to population numbers and payments are made per person, for care received across a number of settings.[3]

However, as reported in the recent Carter review into operational productivity in mental health and community health services; there is wide variation in the commissioning systems being used across the mental health sector and this is having a knock-on effect on efficiency and productivity.[55] Very few providers have moved to the new payment models; only 4% are using the episodic payment system and a further 2% the capitated approach, suggesting that outdated models are still dominating the commissioning landscape. [55]

A long period of financial uncertainty may have contributed to a reluctance to adopt new commissioning models. Year-on-year budget challenges have encouraged conservation of resources and investment in service models that deliver cost savings with little or no improvement in outcomes. Substantial government investment and the introduction of the MHIS may have been expected to alleviate some of the historical financial pressures in the mental health sector but in reality there are still significant challenges:

- CCGs are challenged to raise mental health spending when at a national level, growth in CCG income fell in 2016/17.[10]
- In 2017/18 more than one in ten CCGs failed to meet the MHIS.[9]
- CCGs are under intense pressure to fund a wide range of mental health services; as a result some service providers see little or no increase in investment, whilst investment in some services is accompanied by disinvestment in others:
  - » 83% of secondary care mental health providers did not receive funding increases that matched the overall growth allocations in 2018/19.[56]
  - » MHIS funding is not ring fenced and there are suggestions that much of this allocation has been used to pay off deficits in the acute sector;[36] funding for mental health trusts increased by just 5% from 2012/13 to 2016/2017 compared to an increase of 16.8% for acute hospitals.[57]

How is the continued use of block contracts impacting on the mental health sector and delivery of care for people with schizophrenia?

'Block contracts do not incentivise delivery of the objectives in the Five Year Forward View. They do not facilitate access to timely evidence based care such as those set out in the new mental health access standards.' NHSE and NHS Improvement. Consultation on payment proposals for mental health services for adults and older people commissioned by CCGs in 2016/17. October 2015[58]

Fundamentally, the majority of unaccountable block contracts used to commission mental health services are preventing the NHS from understanding the true cost of care for people with mental health conditions, including schizophrenia, meaning that commissioners cannot plan future services effectively. Research demonstrates that mental health trusts with block contracts in place do not perform as well as those not using block contracts – there were 31% more days of delayed discharges per month associated with services in 2014/15 commissioned with a 100% block contract compared to those commissioned without.[12]

Until the commissioning system is changed and innovative quality and outcomes based systems become the norm, it is unlikely that people living with mental illness will see the benefits of recent investment. Block contracting is associated with several issues that have a detrimental effect on mental healthcare and have contributed to the build-up of perverse incentives within the commissioning system.

Lack of transparency on cost, quality and outcomes

- As providers receive a set payment for the period of the block contract there is little or no requirement to specify how many people are seen within this period or record patients' outcomes and experiences.[2] As a result, both commissioner and provider have a limited understanding of the true cost of the service, whether it is meeting local needs and where improvements need to be made.
- Complacency on quality and outcomes may mean that some people are left in a care setting longer than necessary, delaying discharge and preventing them from being moved appropriately through the care pathway.[12]

Limited opportunity to innovate and integrate other services

- With little detailed information available to monitor and track the efficacy of a service and no financial incentives, there is no impetus for providers to develop or innovate to improve outcomes. Any investment in service redesign would have to come from budget already committed to patient care. This results in problems such as high spending on OAPs as trusts often lack funding to develop or expand their own services, even though these may be more cost effective in the longer term.[48]
- Block contracts also obstruct personalisation and integration of care since no detail is collated about individuals, how they travel through the system or where providers could cooperate to drive improvement. People living with schizophrenia needing care from more than one source may not be able to access everything required if care is offered by different providers with different payment systems.

Cherry picking patients

- Block contracting can lead to providers cherry picking patients; avoiding those with more complex needs as they are likely to consume more budget and resources. When unable to access the right services people may be allocated inappropriate care that does not meet their needs.[59] For example, commissioners don't want to pay for the costly package of care required when taking someone out of secure care – the CCG blocks the patient moving on and they must wait longer to move to a more appropriate care setting.[60]

Commissioning inertia

- Ongoing commissioning of poorly monitored and defined contracts based on historical service provision means that other providers are prevented from offering their services, even if they are more cost effective or more appropriate for patient needs.[12]

Lack of flexibility

- As block contracts rarely allow for variation in demand or increased costs, services may be rationed or quality of care declines due to resource constraints and people may be unable to access the care they require.[53,12]

'Block contracts are not set up for rewarding of the treatment of people living with schizophrenia. They are not efficient nor is quality of care focussed upon and the block contracts do not seem to invite innovation nor do they encourage efficiency.' Hospital Pharmacist

'I would welcome a reform of the payment system in mental health services to encourage a more honest, more effective method that accurately reflects the current needs of the mental health users community, ensuring they receive appropriate care with the essential quality. This will also avoid unnecessary overstaying and delay of patient discharge and the avoidance of the revolving door patient who did not receive adequate care at the last contact with the services.' GP

CHAPTER 6:
IMPROVING SCHIZOPRENIA SERVICES

There are areas across the country where alternative commissioning arrangements are delivering benefits for people living with schizophrenia, commissioners and providers. Publicising existing examples and generating more examples of these best practice approaches will help to encourage and embed their use across the NHS.

'Lining up the reimbursement of services provided in mental health to the newer implemented integrated models of care so that everyone is "singing from the same hymn book" would help unlock more innovation in delivery of mental health services. This would also ensure that newer more efficient way of delivering services will encourage savings in some parts of the service and still hold the finance to spend where it's needed in mental health. This can also greatly contribute to the improvement of the quality of care overall.'

Community Mental Health Nurse.

The NHS has developed an ambitious programme to improve the delivery of mental health services and is aware that commissioning challenges must be overcome if this programme is to be effective. This was reinforced recently in Lord Carter's review of mental health and community health services which found that; *'the way in which services are commissioned directly affects the productivity and efficiency of mental health and community trusts and their contribution to the wider health system.'*[55]

Several programmes and incentives have been put in place to support and encourage adoption of innovation in terms of both commissioning and service redesign.

The Mental Health Dashboard

The Mental Health Dashboard is a transformational tool that claims to provide *'the greatest transparency ever in how the NHS is performing, alongside detail on how mental health services are funded and delivered.'* In reality expanding the Dashboard to provide more granularity on how funding is being distributed and whether it is reaching the right places would increase accountability and help drive improvement.[10,11,36] It is hoped that its evolution will continue to provide new and useful metrics to monitor and drive change in mental health services.

Improvement Incentives - CQUIN Payments and AQP

Commissioning for Quality and Innovation (CQUIN) payments and Any Qualified Provider (AQP) schemes are being implemented in the mental health sector to try and limit the impact of block contracts on quality and patient choice.[59] Mental health is a key focus of the 2017/19 CQUIN with a specific indicator built around reducing A&E attendance through improving and developing integrated services that support people with mental illness more effectively in the community.[62]

Encouraging uptake of new commissioning approaches

Moving towards the new capitated and episodic payment systems will help improve transparency and deliver more integrated services for people. To support this, NHS Improvement has provided a number of resources and guidance on developing new payment approaches and linking payment to quality and outcomes.[3]

GIRFT

The Getting it Right First Time (GIRFT) programme is aimed at improving the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes.[63] The programme covers a range of disease areas and has recently been expanded to encompass mental health. Its key focus is to address the challenge of improving pathway design to reduce out of area placements. However, the Carter Review has identified that there will be significant improvements in commissioning to enable the development of more effective, integrated services that deliver improved outcomes for the patients.[55]

'Outcomes based models are absolutely a right way forward for commissioning mental health. However, the NHS is not currently geared, either organisationally or financially, towards outcomes-based commissioning and lacks the integration between primary care, community care, secondary care and social care that is essential for the success of these new models. A great example from a system including a cohort of GPs that are really getting it right would go a long way to drive momentum back towards outcomes based models.'

An outcomes-based commissioning model for mental health – Oxfordshire Clinical Commissioning Group [64]

In south central England, Oxfordshire CCG has worked with local providers, experts and third sector partners to develop a capitated outcomes-based commissioning model with a payment component linked to achievement of agreed quality and outcomes measures.

The aim of this initiative is to "deliver better outcomes for service users while maintaining financial stability for the local health economy." To ensure mental healthcare provision is evidence based and centred on the needs of the people receiving services, the success of healthcare provision is measured by seven locally developed outcomes measures, rather than by activity. The outcomes were defined based on measures that were most meaningful to service users and each is underpinned by supporting indicators.

In its contract with Oxford Health NHS Foundation Trust, Oxfordshire CCG pays 80% of the total capitated contract value upfront with the remaining 20% linked to the achievement of defined quality and outcomes measures. Of this 20%, 0.5% is linked to national commissioning quality and innovation (CQUIN) payments and 19.5% to the achievement of the locally defined measures. The outcome measures are weighted differently and contribute to different amounts of the 19.5% of the contract value. Both the outcomes and the indicators remain fixed over the duration of the contract. However, in the long term, the indicators, but not the outcomes, may change in response to local needs.

Outcome	Weighting within the contract
People living longer	5%
People improving their level of functioning	20%
People receiving timely access to assessment and support	10%
Carers feeling supported in their caring role	15%
People maintaining a role that is meaningful to them	15%
People continuing to live in stable accommodation	10%
People having fewer physical health problems related to their mental health	15%

CONCLUSIONS

Mental healthcare is in the midst of significant change. There is good intent behind the reforms that whilst being challenging, are aimed at improving outcomes for individuals, the NHS, the economy and society as a whole. It is however, apparent that the system is struggling to adapt to and move away from entrenched practices and behaviours in order to embrace new thinking and move towards parity of esteem.

This is particularly evident within the commissioning environment where quality is being impacted by the way in which care is organised and funded. Outdated financial practices such as block contracting are predominantly focused on activity rather than patient outcomes, limiting opportunities to integrate care and slowing the progress of patients between different care settings. This in turn results in ward overcrowding, bed shortages, OAPs, appointment delays and an increasing use of the Mental Health Act as a means of securing care for vulnerable people with serious mental health needs. Though a number of measures and monitors have been put in place to help signpost areas for improvement to healthcare professionals and commissioners, explicit financial practices in mental healthcare have not been singled out for closer analysis.

Schizophrenia is one of the most complex and challenging conditions to manage within the mental illness spectrum. Despite a prevalence of 1%, schizophrenia has a disproportionate impact on NHS resources with relapse and hospitalisation being the main drivers of costs. It is also an area in which redefining the relationships between commissioners and providers to encourage the implementation of more accountable financial approaches offers a significant opportunity to improve patient outcomes and alleviate financial pressures. This could better facilitate the movement of patients through the care system without getting blocked in hospital or sent on a costly OAPs because of perverse incentives built up through block contracting.

Whilst some areas are beginning to move towards more transparent and value-for-money partnerships that help secure better outcomes for people with mental ill health, progress is slow and better dissemination of these positive examples is needed to encourage wider uptake of new approaches. This report concludes that until significant moves are made to improve accountability within the commissioning system and incentivise the adoption of outcomes and quality based commissioning approaches, there will be little improvement in frontline services for people with serious mental illnesses such as schizophrenia. The mental health sector is under considerable pressure and needs more support in delivering the widespread improvements that are required of it.

This report calls on the Department of Health and NHS England to address a number of areas which could reinvigorate progress in this area and help pave the way towards greater parity for mental and physical health.

CALL TO ACTION

Mental health needs more funding if it is to achieve parity of esteem with physical health. In addition, better data is also needed to reduce the variation in care that patients receive. Data around commissioning of mental healthcare can improve measurement and enable effective management of performance against outcomes. This report recommends:

1. A review of mental health clustering to better reflect care pathways, increase usability, improve data collection and drive increased use.
2. Revising the Mental Health Dashboard to include:
    a. Improved information and advice to ensure greater consistency in reporting
    b. Data on the use and monetary value of block contracts
    c. Increased granularity and additional spending metrics on readmission and relapse
    d. Operational performance data for people treated in secondary care and community care under a mental health trust
    e. Outcomes data
    f. Service user and carer experience data
3. Increased access to resources and templates to support the move to new models of commissioning services and dissemination of examples of alternative, outcomes-based commissioning models.
4. Incentivised commissioning to promote uptake of quality and outcomes-based service design, for example linking outcomes to NICE guidelines and quality standards for consistent delivery and reduced variation.

REFERENCES

1. Prime Minister's Office. Press Release. Prime Minister pledges a revolution in mental health treatment. 11 January 2016. Available at: https://www.gov.uk/government/news/prime-minister-pledges-a-revolution-in-mental-health-treatment Last accessed November 2018.
2. NHS England. The five year forward view for mental health: a report from the independent Mental Health Taskforce to the NHS in England. February 2016. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf Last accessed November 2018.
3. NHS Improvement. New payment approaches for mental health services. Available at: https://improvement.nhs.uk/resources/new-payment-approaches/ Last accessed November 2018.
4. NHS England and NHS Improvement. NHS Operational Planning and Contracting Guidance 2017-19. September 2016. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf Last accessed November 2018.
5. Prime Minister's Office. Press Release. Prime Minister unveils plans to transform mental health support. 9 January 2017. Available at: https://www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support Last accessed November 2018.
6. Department of Health and Social Care. Press release. £15 million boost for local mental health crisis services. 25 May 2018. Available at: https://www.gov.uk/government/news/15-million-boost-for-local-mental-health-crisis-services Last accessed November 2018.
7. Department of Health and Social Care. Press release. Prime Minister sets out 5-year NHS funding plan. 18 June 2018. Available at: https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan Last accessed November 2018.
8. The Independent. Budget 2018: Mental health services to receive £2bn per year boost Phillip Hammond will say. Monday 29 October 2018. Available at: https://www.independent.co.uk/news/uk/politics/mental-health-budget-2018-philip-hammond-nhs-theresa-may-a8605466.html Last accessed November 2018.
9. Royal College of Psychiatrists. Interactive web tool. Is your CCG meeting the national mental health investment standard?
10. Kings Fund. Funding and staffing of NHS mental health providers: still waiting for parity. 16 January 2018. Available at: https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers Last accessed November 2018.
11. Gammie J. Mental Health Matters: CCGs can't work miracles. Health Service Journal, 9 April 2018. Available at: https://www.hsj.co.uk/mental-health/mental-health-matters-ccgs-cant-work-miracles/7022117.article Last accessed November 2018.
12. Independent Mental Health Services Alliance. New research shows impact of poor commissioning in mental health. October 2015. Available at: http://www.imhsa.org.uk/upload/files/IMHSA_policypapers_31_146215583.pdf Last accessed November 2018.
13. Thomas S, Thomas S, Rowe P. Measuring the Burden of Schizophrenia: A cross sectional analysis of the Mental Health Services data set and the English Hospital Episode Statistics data set. Basildon, Essex: Wilmington Healthcare Ltd. April 2018.
14. Royal College of Psychiatrists. Schizophrenia. August 2015. Available at: https://www.rcpsych.ac.uk/healthinformation/problemsanddisorders/schizophrenia.aspx Last accessed November 2018.
15. Rethink Mental Illness. Schizophrenia. Available at: https://www.rethink.org/diagnosis-treatment/conditions/schizophrenia?gclid=CKq9lPGyt9ECFQmeGwodxbUAOA Last accessed November 2018.
16. NHS Choices. Schizophrenia: causes. Available at: https://www.nhs.uk/conditions/schizophrenia/causes/ Last accessed November 2018.
17. Schizophrenia Commission. The abandoned illness. November 2012. Available at: https://www.rethink.org/media/514093/TSC_main_report_14_nov.pdf Last accessed November 2018.
18. Parks J, Svendsen D, Singer P, Foti ME. Morbidity and mortality in people with serious mental Illness. Alexandria, VA, USA: National Association of State Mental Health Program Directors, Medical Directors Council, 2006. Available at: https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf Last accessed November 2018.
19. Partti G, Vasankari T, Kanervisto M, et al. Lung function and respiratory diseases in people with psychosis: Population-based study. Br J Psychiatry. 2015;207:37-45.
20. Harris EC, Barraclough B. Suicide as an outcome for mental disorders: a meta-analysis. Br J Psychiatry. 1997;170:205-28.
21. Gupta S, Isherwood G, Jones K, van Impe K. Assessing health status in informal schizophrenia caregivers compared with health status in non-caregivers and caregivers of other conditions. BMC Psychiatry. 2015;15:162.
22. Kings Fund. Making shared decision-making a reality: no decision about me, without me. 2011. Available at: https://www.kingsfund.org.uk/sites/default/files/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf Last accessed November 2018.
23. Commission to review the provision of acute inpatient psychiatric care for adults. Improving acute inpatient psychiatric care for adults in England: interim report July 2015.
24. NHS Choices. Schizophrenia: treatment. Available at: https://www.nhs.uk/conditions/schizophrenia/treatment/ Last accessed November 2018.
25. NHS England. HES Online. NHS Accident and Emergency (Experimental Statistics), 2011-12: Table of Contents Table 14: Number of A&E attendances, A&E primary diagnosis '2 character description field' 2010-11 and 2011-12. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2011-12 Last accessed November 2018.
26. NHS England. Hospital Accident and Emergency Activity - 2016-17. Table 18: Number of A&E Attendances, A&E Primary Diagnosis '2 character description field' 2015-16 and 2016-17 (HES). Available at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2016-17 Last accessed November 2018.
27. Andrew A, Knapp M, McCrone P, Parsonage M, Trachtenberg M. Effective interventions in schizophrenia: the economic case. A report prepared for the Schizophrenia Commission. Personal Social Services Research Unit, London School of Economics. November 2012. Available at: http://eprints.lse.ac.uk/47406/7/__libfile_repository_Content_Knapp%2C%20M_Effective%20Interventions%20in%20schizophrenia%20the%20economic%20case_Effective%20Interventions%20in%20schizophrenia%20%28LSERO%29.pdf Last accessed November 2018.
28. Rethink Mental Illness. Investing in recovery: making the business case for effective interventions for people with schizophrenia and psychosis. April 2014. Available at: http://eprints.lse.ac.uk/56773/1/Knapp_etal_Investing_in_recovery_2014.pdf Last accessed November 2018.
29. Rt. Hon Jeremy Hunt MP. Oral statement to Parliament: mental health and NHS performance. 9 January 2017. Available at: https://www.gov.uk/government/speeches/mental-health-and-nhs-performance Last accessed November 2018.
30. McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S. Paying the price: the cost of mental health care in England to 2026. King's Fund, May 2008. Available at: https://www.kingsfund.org.uk/sites/default/files/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf Last accessed November 2018.
31. Simpson GM. Atypical antipsychotics and the burden of disease. Am J Manag Care. 2005;11(8,Suppl.): S235 41.
32. NHS Digital. Hospital Episode Statistics for England. Admitted Patient Care Statistics, 2016-17. Primary Diagnosis Summary. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2016-17 Last accessed November 2018.
33. NHS reference costs 2015/16. December 2016. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf Last accessed November 2018.
34. Ambulance call-outs for mental health patients in England soar by 23%. Guardian, 13 August 2017. Available at: https://www.theguardian.com/society/2017/aug/13/ambulance-call-outs-mental-health-patients-soar-23-per-cent Last accessed November 2018.
35. The Mental Health Foundation. Fundamental facts about mental health 2015. Available at: https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2015 Last accessed November 2018.
36. British Medical Association. Lost in transit: funding for mental health services in England. 2018. Available at: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/mental-health/funding-mental-health-services Last accessed November 2018.
37. The Health and Social Care Act 2012. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted Last accessed November 2018.
38. Health Foundation, Nuffield Trust. Cause for concern. QualityWatch annual statement, October 2014. Available at: http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QW%20annual%20statement%2014%20%28final%29.pdf Last accessed November 2018.
39. Royal College of Psychiatrists, Centre for Mental Health. Bridging the gap: the financial case for a reasonable rebalancing of health and care resources. October 2013. Available at: https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/b/r/i/bridging-the-gap-the-financial-case-for-a-resonable-rebalancing-of-health-and-care-resources.pdf Last accessed November 2018.
40. Care Quality Commission. Right here right now: people's experiences of help, care and support during a mental health crisis. June 2015. Available at: https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf Last accessed November 2018.
41. Bulman M. Mental health spending cut despite more people seeking help, new figures reveal. The Independent, 26 July 2017. Available at: https://www.independent.co.uk/news/uk/home-news/mental-health-referrals-surge-spending-falls-figures-show-five-live-trusts-a7861971.html Last accessed November 2018.
42. Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West. Developing Models for Liaison Psychiatry Services – Guidance. 1st edition, February 2014. Available at: https://mentalhealthpartnerships.com/wp-content/uploads/sites/3/3-developing-models-for-liaison-psychiatry-services.pdf Last accessed November 2018.
43. All-Party Parliamentary Group on Mental Health. Progress of the Five Year Forward View for Mental Health: On the road to parity. October 2018. Available at https://www.rcpsych.ac.uk/pdf/APPG-on-Mental-Health-Progress-of-the-FyFV-MH-On-the-road-to-parity.pdf Last accessed November 2018.
44. Care Quality Commission. NHS patient survey programme: 2016 Community Mental Health Survey Statistical release. Published November 2016. Available at: https://www.cqc.org.uk/sites/default/files/20161115_cmh16_statistical_release.pdf Last accessed November 2018.
45. Right Treatment, Right Time. Rethink Mental Illness. November 2018. Available at: https://www.rethink.org/get-involved/campaigns/right-treatment-right-time-report Last accessed November 2018.
46. NHS Digital. Out of area placements in mental health services. May 2018. Available at: https://files.digital.nhs.uk/A4/44D85A/oaps-rep-may-2018.pdf Last accessed November 2018.
47. Commission to Review The Provision of Acute Inpatient Psychiatric Care for Adults. Old problems, new solutions: improving acute psychiatric care for adults in England. Final Report. February 2016.
48. NHS Digital. Mental Health Act Statistics, Annual Figures 2016/17, Experimental Statistics. October 2017. Available at: https://files.digital.nhs.uk/pdf/b/t/ment-heal-act-stat-eng-2016-17-summ-rep.pdf Last accessed November 2018.
49. Royal College of Psychiatrists. Sectioned for a bed: results of our RCPsych survey of trainee psychiatrists. June 2014. Available at: https://psychiatrysho.wordpress.com/2014/06/02/sectioned-for-a-bed-results-of-the-rcpsych-survey-of-trainee-psychiatrists/ Last accessed November 2018.
50. NHS. Stepping forward to 2020/21: the mental health workforce plan 2017. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf Last accessed November 2018.
51. NHS Digital, NHS Workforce Statistics, August 2017 Staff Group, Area and Level. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics-august-2017-provisional-statistics Last accessed November 2018.
52. Kings Fund. Workforce Planning in the NHS. April 2015. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf Last accessed November 2018.
53. BMA. Models for paying providers: block contracts. June 2015. Available at: https://www.bma.org.uk/connecting-doctors/policy_debate/new_integrated_care_models/m/bma_briefings/335 Last accessed November 2018.
54. Department of Health. Payment by results guidance for 2012-13. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216212/dh_133585.pdf Last accessed November 2018.
55. NHS Operational Productivity: unwarranted variations. Mental health services, community health services. May 2018. Available at: https://improvement.nhs.uk/about-us/corporate-publications/publications/lord-carters-review-unwarranted-variations-mental-health-and-community-health-services/ Last accessed November 2018.
56. Healthcare Financial Management Association, Mental Health Finance Faculty. Mental health investment standard. June 2017. Available at: https://www.hfma.org.uk/docs/default-source/our-networks/faculties/mh-finance-faculty-information/mh-finance-faculty/mental-health-investment-service-2017 Last accessed November 2018.
57. Kings Fund. Press Release: Mental health funding gap widens further. 16 January 2018. https://www.kingsfund.org.uk/press/press-releases/mental-health-funding-gap-widens-further Last accessed November 2018.
58. NHS England, Monitor. Consultation on payment proposals for mental health services for adults and older people commissioned by CCGs in 2016/17. 21 October 2015. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/10/mh-consult-letter-oct15.pdf Last accessed November 2018.
59. Health Foundation, NHS Providers. Towards an effective NHS payment system: eight principles. October 2017. Available at: https://www.health.org.uk/sites/health/files/EffectivePaymentSystemEightPrinciples.pdf Last accessed November 2018.
60. Independent Mental Health Services Alliance. Breaking down barriers: improving patient access and outcomes in mental health. November 2015. Available at: http://www.imhsa.org.uk/upload/files/IMHSA_policypapers_30_790927026.pdf Last accessed November 2018.
61. NHS England. Mental Health Five Year Forward View Dashboard. Available at: https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/ Last accessed November 2018.
62. NHS England. Commissioning for Quality and Innovation (CQUIN). Guidance for 2017-2019. March 2018. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf Last accessed November 2018.
63. Royal National Orthopaedic Hospital NHS Trust, NHS Improvement. Getting it Right First Time (GIRFT) programme. Available at: http://gettingitrightfirsttime.co.uk/ Last accessed November 2018.
64. NHS Improvement and NHS England. Oxford Health NHS Foundation Trust outcome based commissioning model for mental health: Updated outcome measures. August 2016. Available at: https://improvement.nhs.uk/documents/234/MH_outcome_based_commissioning_update_note_v2.pdf Last accessed November 2018.


janssen