



All Party Parliamentary Group on Mental Health

**Health and Social Care  
Reform:  
Making it work for mental health**

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# i. Foreword

**I am delighted to introduce this report, which concludes the All Party Parliamentary Group on Mental Health's inquiry into the impact of recent NHS reforms on mental health services. Over the course of a year we took evidence from people with mental health problems, carers, the Minister for Care Services, clinicians, voluntary sector providers and representatives of minority groups. This report sets out their views on the potential threats and opportunities created by the NHS reforms, and our recommendations for politicians and commissioners.**

For too long mental health has been neglected in the NHS; a misunderstood 'Cinderella' service, consistently in the shadow of physical health. If ever there was a time to redress this balance, it must surely be now. As the transition to new structures takes place, we must look again at how we can improve the choice, consistency and quality of care on offer: how do we create an NHS that truly empowers mental health service users, and truly responds to their whole-person needs? It is a chance we cannot afford to miss.

In the inquiry's five sessions we heard a mix of enthusiasm and concern: enthusiasm at the prospect of patient-centred commissioning, and the potential to ensure services reflect the needs of people with mental health problems; and concern regarding cuts to funding and uncertainty over GPs' ability to commission services.

The coalition government has done much to raise the profile of mental health. It has invested significant sums of money in talking therapies and the anti-stigma campaign, Time To Change. And it has adopted a pledge for parity of esteem between mental and physical health in the Health and Social Care Act. We as Members of Parliament must work hard to ensure this momentum continues and that this principle of parity is applied across the health care system.

Our recommendations, drawn from the evidence we heard, are realistic steps to achieving better mental health care for our constituents. One in four of us will experience mental health problems at some point in our lives. Now is the time to ensure we have access to quality care and support when we need it.

Ever yours,

**Charles Walker MP**

Chair of the All Party Parliamentary Group on Mental Health

## ii. Executive Summary

**The All Party Parliamentary Group on Mental Health (APPGMH) aims to raise the profile of mental health issues and to act as a political avenue for those affected by them. In April 2011, the APPGMH launched a year-long inquiry into the effect that the reforms contained in the Health and Social Care Bill would have on both mental health services and those that use them.**

Too often health care reform is focussed on physical health services, leaving mental health services to be fitted to systems that do not reflect their needs. The APPGMH was concerned that mental health could again lose out, despite its impact on the population and the NHS. The purpose of the inquiry was therefore to explore the potential challenges and difficulties posed by the reforms, and make recommendations for overcoming any such challenges.

From the five evidence sessions, four areas emerged in which there were key concerns:

**1. Commissioning:** GPs may not possess enough knowledge of mental health problems to commission mental health services effectively. We must make sure the services that are commissioned reflect the needs of people with mental health problems, to avoid good care becoming a postcode lottery.

**2. Local Decision Making:** There is a need to ensure mental health features prominently in local health plans, so that people with mental health problems are encouraged to play a part in local decision making processes, and that public health professionals understand that mental health sits in their remit.

**3. Integrated Care pathways:** Too many people find themselves lost in a maze of assessments when trying to access the health and social care services they need. Joining up services and simplifying access is an urgent priority.

**4. Personalisation and patient choice:** Too often, people with mental health problems find it difficult to access services, are offered little choice about their treatment, and are not meaningfully involved in planning their own care. The personalisation agenda, including personal health budgets, must apply equally to mental health with people supported to have greater choice and control.

Our recommendations address these concerns and were drawn from the evidence we heard. They focus on two groups: the bodies who will make decisions on services and national policy makers who can ensure that mental health gets the attention it needs.

## iii. Recommendations

### **Local decision makers**

#### **Clinical Commissioning Groups:**

- 1.** Commission a wide range of mental health services across primary, secondary and crisis care, which promote equal access, early intervention, choice and recovery, based on NICE quality standards and Joint Commissioning Panel guidance.
- 2.** Appoint a mental health lead at senior level to provide expertise and ensure a strategic focus on mental health.
- 3.** Establish a sub-committee of local mental health professionals, providers and people with experience of mental health problems to inform commissioning decisions and build relationships between CCGs and existing services.

#### **Health and Wellbeing boards:**

- 1.** Ensure local mental health is properly assessed and given appropriate priority across public health, NHS, social care and other council services, in the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.
- 2.** Use a range of engagement mechanisms to involve people with mental health problems in developing Joint Strategic Needs Assessments, including proactive engagement with hard to reach and Black minority ethnic groups.
- 3.** Ensure mental health receives priority equal to physical health, by appointing a board member as mental health lead and actively involving local voluntary sector organisations and mental health professionals.

### **National policy makers**

#### **Government:**

- 1.** Ensure the NHS Commissioning Board is mandated to deliver parity of esteem between mental and physical health.
- 2.** Ensure the personalisation agenda, including personal health budgets, is equally applied to mental health, with high quality information and support available to enable people with mental health problems to exercise choice and control over their care.
- 3.** As payment-by-results is rolled out in mental health, support ongoing work to develop effective and meaningful NHS tariffs for mental health, which include patient-reported outcome measures.

#### **MPs:**

- 1.** Send this report to your local health bodies and highlight the recommendations.
- 2.** Ask your local CCG groups to appoint a mental health lead to guide service provision.
- 3.** Monitor the state of mental health services in your constituency.

## iv. Evidence Sessions and Speakers

### **Session 1:**

#### **'NHS reform and its impact on Mental Health services',**

Monday, 14<sup>th</sup> March 2011 2.00pm – 3.00pm.  
Speaker Panel: Paul Burstow MP, *Minister for Care Services*

### **Session 2:**

#### **'Service users speak out',**

Tuesday, 17th May 2011, 2.00pm – 3.00pm.  
Speaker Panel: Caroline Hough; Neil Campbell; Vincent George; Diane Hackney and an anonymous service user.

### **Session 3:**

#### **'Commissioning mental health services',**

Tuesday 6th September 2011, 2.00pm – 3.30pm.  
Speaker Panel: Co-chairs of the Joint Commissioning Panel for Mental Health: Dr Neil Deuchar, *Royal College of Psychiatrists* and Professor Helen Lester, *Royal College of GPs*; Dr Caroline Lea-Cox, *Mental Health lead, GP Senate, NHS Cambridgeshire*

### **Session 4:**

#### **'Impact of health reforms on mental health charities at a local level',**

Tuesday 29th November 2011, 2.00pm – 3.30pm. Speaker Panel: Richard Pacitti, *Chief Executive of Mind in Croydon*; Ian Bowden, *Area Manager Devon, Cornwall, Plymouth & Torbay, Rethink Mental Illness*; Gemma French, *Service Manager for Crisis Point in Manchester*.

### **Session 5:**

#### **'Reducing Inequalities in Mental Health Care for minority groups',**

Wednesday 7th March 2012, 2.00pm – 3.30pm. Speaker Panel: Matilda MacAttram, *Director, Black Mental Health UK*; Patrick Vernon, *Director, The Afiya Trust*; Hamza Anwar, *steering group member and service user, Catch-a-Fiya Network*; Rakshita Patel, *steering group member and service user, Catch-a-Fiya*; Elsie Gayle, *African Caribbean Community Initiative (ACCI) Carer, member of National Black Carers and Careworker Network and The Afiya Trust*; Dr Peter Connolly, *Chair of the Royal College of Psychiatrists' Faculty of Old Age Psychiatry*;

## v. Introduction

**In 2010 the coalition government announced its intention to overhaul the health service, with a view to creating a patient-centred and clinician-led health system. The reforms that followed and culminated in the Health and Social Care Act 2012 have been seen by some as some of the biggest restructuring of the National Health Service since its launch in 1948.**

The key aspects of the reforms included:

- The establishment of the **NHS Commissioning Board** to allocate resources and provide commissioning guidance.
- Creation of **Clinical Commissioning Groups** (CCGs), led by GPs, with responsibilities for commissioning local services.
- The abolition of **Primary Care Trusts** and **Strategic Health Authorities** and the introduction of **Health and Wellbeing Boards**, with the function to encourage integrated commissioning
- The development of **Monitor** as the economic regulator for all NHS funded services
- The **Care Quality Commission** (CQC) will continue to act as the quality inspectorate across health and social care and will register services to ensure quality standards are maintained.

- The creation of **local Healthwatch organisations** and **Healthwatch England** to gather and represent the views of patients.

After completing its initial stages in the House of Commons the legislation was 'paused' to allow the government to consult on further changes to the Bill.

The Bill's passage through parliament saw a number of key amendments tabled which explicitly addressed mental health. These amendments led to a commitment to retain joined-up mental health 'aftercare' services for people who have been detained under the Mental Health Act, and a responsibility on the Secretary of State to promote both physical and mental health.

The Government published its Mental Health Strategy, 'No health without mental health' in February 2011, as the reforms were progressing through Parliament. The strategy provides a clear vision for securing an improvement in the mental wellbeing of the nation. Its six objectives are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm

- Fewer people will experience stigma and discrimination

An Implementation Framework for the strategy is due to be published soon and should be used as a resource for commissioners, clinicians and other service providers to inform commissioning and decision making in the new devolved health and social care system.

The APPGMH welcomed the original intentions behind the Health and Social Care Act – to increase patient involvement and to better integrate health and social care – and the successful amendments. We also welcome and support the objectives set out in the Mental Health Strategy, but have concerns about the interface between the Act and the Strategy. We hope that the recommendations set out in this report will enable Members of Parliament to work with local commissioners to achieve improvements for everyone with mental health problems.

At the time of writing we are hopeful that the Secretary of State's Mandate to the NHS Commissioning Board will have a strong focus on delivering parity of esteem between physical and mental health.

# 1. Commissioning Mental Health Services

- 1.1. Reforming the way in which services are commissioned forms the cornerstone of the changes to the NHS. The 'Liberating the NHS' White Paper<sup>1</sup> outlined proposals to give GPs and health professionals more autonomy, empowering them to take control of commissioning services in local teams, or 'GP consortia' (later changed to Clinical Commissioning Groups or CCGs). The Government argued that giving commissioning responsibility to health care professionals would lead to services better reflecting patients' needs, and would make services more accountable at a local level.
- 1.2. The potential of GP commissioning was addressed in each evidence session, and key themes emerged: the suitability of GPs to commission services specific to mental health, the future role of voluntary sector providers, and commissioning for hard to reach groups.
- 1.3. **Concerns were raised in each evidence session that GPs may not possess the expertise and experience to commission mental health services, and that access to good quality care would become a postcode lottery.**
- 1.4. The service users we heard from suggested that, while some GPs have a good knowledge of local clinical and social mental health care services, others do not instil confidence. Many GPs prefer to prescribe medication for a mental health problem, rather than approach treatment holistically and refer patients to psychological therapies, peer-to-peer support networks or community based services. This is supported by recent research by Mind which reported that 30 per cent of patients found their GP was unaware of services to support mental health recovery beyond medication<sup>2</sup>. Yet people are three times more likely to be satisfied with their treatment if they are presented with a choice of treatments<sup>3</sup>.
- 1.5. The service users stated that many people with mental health problems do not trust their GPs, because of previous bad experiences; failures to refer to appropriate services; and lack of involvement in or autonomy over their own care.

## GP expertise in mental health

- 1.3. **Concerns were raised in each evidence session that GPs may not possess the expertise and experience to commission mental health services, and that access to good quality care would become a postcode lottery.**

- 1.6. Concern was expressed that the Bill didn't provide for training for GPs. But commissioners, service users and the Minister for Care Services agreed that steps must be taken to ensure GPs are adequately supported to understand the needs of people with mental health problems and to make the right commissioning choices. To do so, more informal arrangements must be put in place to encourage CCGs to make use of external expertise in mental health.
- 1.7. A number of organisations have come together over the past year to form the Joint Commissioning Panel for Mental Health (JCP-MH) and address concerns about the future commissioning of mental health services. The body – which includes amongst others the Royal College of Psychiatrists, Royal College of General Practitioners, Rethink Mental Illness and Mind – is providing the practical guidance that commissioning groups, local authorities, and Primary Care Trusts in transition will need to be able to commission for mental health and wellbeing.

**Consulting on expertise**

- 1.8. The service users we heard from unanimously agreed that “No decision about me, without me” should be the defining principle for commissioning and designing services in mental health. This idea would complement**

**potential gaps in clinicians’ knowledge of what services work for patients.**

- 1.9. CCGs should ensure they provide quality services by drawing on external expertise, including from people with direct experience of mental health problems who have used the mental health and social care system, and know what works.
- 1.10. Local voluntary groups, patient and carer groups and mental health professionals are also well placed to help provide this advice and should be given the opportunity to provide meaningful input into the design and commissioning of services. This participation could be fulfilled most effectively by a presence on Health and Wellbeing Boards, Healthwatch groups, and through liaison with CCGs.
- 1.11. General lay representation on these boards is legislated for in the Bill. But the evidence we heard suggested that this mechanism was for transparency, and would not mean greater patient representation. There were concerns that mental health would continue to be overlooked if legalisation did not provide an opportunity for people with mental health problems to input to discussions. Mental health does not enjoy the same public health profile of conditions such as cancer, diabetes and heart disease, and is easily overlooked, especially in times of tightened financial resources.

**Commissioning voluntary sector providers**

**1.12. The voluntary sector offers a wealth of expertise and experience in providing support services alongside the NHS. Often, it is the peer-to-peer support offered by voluntary sector organisations that is most desired by service users.**

1.13. The Minister for Care Services acknowledged that the voluntary sector often offers services that are more in tune with people's needs (when compared to the NHS and private providers). He suggested that the 'Any Willing Provider' policy<sup>4</sup> will enable voluntary organisations to assume a more prominent role in providing NHS services. Any organisation that is prepared to work on the basis of NHS prices, and to NHS quality standards, will be able to bid to provide a service.

1.14. The voluntary sector panellists we heard from were concerned that in reality, commissioners would not give due consideration to the unique, holistic qualities that the sector brings to individuals and local communities. Many of the 'softer' mental health services provided by the voluntary sector, such as gardening projects, exercise groups and befriending networks, are clinically recognised as both effective for service users and financially cost-effective for commissioners and the NHS. But the voluntary sector panellists feared that not many commissioners would

understand this, and such services would be de-commissioned.

1.15. Some expressed concern that commissioners are focused on delivering savings of £20 billion by 2015 and are therefore likely to favour larger private healthcare providers who may appear more cost effective because of volume and scale. Anecdotal examples of commissioners choosing services based on price, not quality were given.

1.16. It was noted that private providers are often better able to tender for services due to their larger staff teams and expertise in doing so. In order to compete with private providers, some charities have begun to form local coalitions with other small providers. But whilst this may enable them to offer a broader range of services to commissioners, it does not necessarily guarantee they will be more competitive on price.

1.17. The Minister for Care Services stated that it is time to move away from a cost and volume model of commissioning mental health services and begin to focus on quality. Nationally set tariffs will make it easier for commissioners to choose the right provider, and ensure that the commissioners focus on improving quality and outcomes, not price. The government, he added, is committed to introducing nationally fixed tariffs for providing mental health services but work in this area is still very much in development.

**Paul Burstow MP, Minister for Care Services on commissioning voluntary sector services:**

*"We know already that there are some very good exemplars of services that are much more in tune with patient wishes, needs and expectations that are provided by the voluntary sector. The 'Any Willing Provider' policy opens the door to those opportunities to become much more widely taken up."*

### **Commissioning services for hard to reach groups**

#### **1.18. Mental health services must be responsive to the needs of seldom heard groups such as the elderly or black minority ethnic (BME) communities, and choice and access to mental health services must be improved.**

1.19. Research shows that some BME communities have higher a rate of mental health problems. Despite this, representatives of BME groups said that people from these backgrounds often face barriers in accessing mental health services, such as Independent Mental Health Advocacy and psychological therapies. Services are seldom tailored to meet specific cultural needs, such as language and faith, and an increased stigma in some BME communities towards mental health can further hinder access. It was felt that GPs might find it particularly hard to commission a blend of culturally appropriate specialist services for diverse ethnic groups.

1.20. The draft Commissioning Outcomes Framework for the NHS contains clear outcomes relating to commissioning for the needs of BME communities, but it is likely that GPs will require additional assistance in understanding the diverse range of services that are needed. It was suggested that training for GPs should include an element that specifically focuses on commissioning for ethnically diverse communities.

1.21. Voluntary and community organisations and members of BME communities may be better aware of the specific needs of BME communities and should be used to help address any shortfall in clinician's knowledge.

1.22. MPs agreed with panellists that outreach to diverse and hard to reach groups should be proactively undertaken by commissioning groups. BME groups must be able to give feedback about their experience of services, particularly within local HealthWatch groups, and be empowered to articulate what they need. Some believed that the Bill could have gone further in championing the patient voice or the voice of carers and voluntary organisations, in commissioning.

## 2. Local Decision Making for Mental Health Services

2.1. The Health and Social Care Act provides an opportunity to shape services so that they meet local populations' health and social care needs. It transfers power from central government to local authorities and to the newly created Health and Wellbeing Boards (HWBBs) and Clinical Commissioning Groups (CCGs) who, the Government argues, will be able to more accurately access the health and social care needs of the local population.

### Joint Strategic Needs Assessments

**2.2. Health and Wellbeing Boards are required to identify the health needs of the local population through a Joint Strategic Needs Assessments (JSNA). The information from the JSNA will inform the Joint Health and Wellbeing Strategies (JHWS), which provides the strategic guidance for local commissioning by CCGs.**

2.3. JSNAs need to accurately assess the extent of mental health needs in the local population. But panelists pointed out that historically, JSNAs have not done enough to accurately capture mental health needs. They have relied too heavily on data taken from GPs' Severe Mental Illness Register, or extrapolated from the Survey of

Psychiatric Morbidity Among Adults Living in Private Households. These measures are inadequate for building a picture of community mental health as many people with mental health problems are not formally diagnosed or known to services.

2.4. As a consequence of inaccurate data, mental health often loses priority and funding to other health conditions, which are better understood and less stigmatised. Concerns were expressed that, despite the restructuring, the interests of people with mental health problems will continue to be inadequately represented at a local level.

2.5. There is increasing awareness of the relationship between poor mental health and poor physical health, and increased understanding that ignoring mental health problems is a false economy. Panelists felt that Health and Wellbeing Boards will need additional specialist help to accurately assess the extent of mental health needs locally for the JSNA. This support and intelligence could be provided by local mental health groups and practitioners who understand that some people may have trouble in engaging through traditional support because they lack capacity or have communication difficulties

Matilda MacAttram, Director, Black Mental Health UK, on commissioning for hard to reach groups:

*"...unless you have a really big and really powerful voice, there's so many other priorities that it's like one of those, "Oops! Oh yes, we'll deal with it", and then because of all the other pressures it doesn't get dealt with. So there is an awareness but there isn't the equivalent addressing of the issues."*

### **Patient engagement in local decision making**

- 2.6. Steps must be taken to guarantee that mental health service users have meaningful input into shaping local health priorities. There was consensus from panelists that people with mental health problems do not have equal or adequate opportunities to input into local decision making processes.**
- 2.7. Involving patients in local decision making processes will ensure that Health and Wellbeing Boards and Clinical Commissioning Groups prioritise the mental health services that are appropriate for local population needs. Too often views are only collected after services have been used. Whilst it is important to monitor patient satisfaction rates, gathering patients' expectations and involving people in service design through active involvement prior to commissioning, is the best way to ensure the right services are delivered from the outset.

### **Consulting on expertise**

- 2.8. The new overview and commissioning groups must use a range of tools to ensure that they reach all groups, especially marginalised and vulnerable groups, when consulting on local decisions. Seldom heard communities, such as BME groups or people receiving long term inpatient care, do not always have the means to respond to formal consultations, and this leads to an incomplete and inaccurate picture of the community's real health and social care needs.**
- 2.9. Wider service user involvement should be sought at every stage of assessment and commissioning, to ensure services are delivered based on an adequate assessment and understanding of the needs of the local population.
- 2.10. Service user panelists suggested a range of options for consulting with harder to reach groups, including email surveys, focus groups, postal surveys, internet forums and Facebook groups.

# 3. Integrated Care Pathways

3.1. The case for integrated care services has been well made by many. People with mental health problems often require a combination of health and social care services as part of their on-going treatment, or 'care pathway'. In order to stay well in the community, a person might need, for example, support with keeping on top of household bills or forms, help with personal care, 'meals on wheels', access to a befriending service, medication and psychological therapy. But services are notoriously difficult to navigate - people often find themselves lost in a maze of assessments and appointments. In too many cases, these assessments are conducted by a number of different professionals who fail to work together to understand the needs of the whole person.

3.2. The NHS Future Forum, formed in April 2011 to 'pause, listen and reflect' on the Health and Social Care Bill and make recommendations for the direction of legislation, stressed the need to continue the effort towards integrated health and social care services. Its recommendations emphasised that the direction of the Bill should be towards:

- integration around the patient, not the system

- making it easier for patients and carers to coordinate and navigate the care services
- allowing the funding to follow the patient

The Forum argued that Health and Wellbeing Boards could and should become the place where the integration of health and social care is forged. Discussions during the inquiry focused on what meaningful integration should look like and how it might be achieved.

## Patients' records

**3.3. One of the most common complaints of people with mental health problems relates to health professionals failing to share information and liaise properly with each other.**

3.4. People with mental health problems depend upon a combination of medical, psychological (such as 'talking therapies'), community and social care services to help maintain their mental health. In the reformed health care system, an even larger number of commissioning organisations and service providers will be involved in a patient's care pathway.

- 3.5 It is vital that patient records are effectively shared between those health professionals across primary and secondary healthcare providers, and between different spheres of care, so that patients do not have to constantly re-tell their medical history. As well as being an unproductive use of time, recalling details that should already be held can be very distressing if a person is in crisis.
- 3.6. Service providers stated that the best way to overcome these difficulties would be to develop and expand the use of accessible electronic care records at each point of care. Until then, the mental health service users felt that they were best placed to manage the transfer of their own care records between providers. Information about records belongs to patients, and individuals so should be encouraged, where appropriate, to retain their own personal service records. They should be supported in doing so by health professionals.
- 3.8. Patients enter the mental health care system at either the primary or secondary level, but many report that there are problems with sharing information between the two. The panel of service users said that often people who have experience of a mental health problem will be aware of when they need help again, and they might know what services will help them stay well.
- 3.9. But too often they are prevented from taking timely control of their health because the system usually requires them to be referred at two levels: primary and secondary. The service users and commissioners we heard from felt that patients with a history of mental health problems should be able to self-refer directly, or have instant access, to secondary services such as community mental health nurses or talking therapies.
- 3.10. For some groups, such as men and people from some BME communities, being able to self-refer is preferable to having to go through a GP. Currently, self-referral is only a realistic option for some services provided by voluntary sector organisations. The panel of service users were frustrated by the hurdles they had to jump through in order to access services and believed that self-referral should be more widely available.

#### **Simplified referrals system**

- 3.7. The process of referring between services needs to be improved. At the moment it is too complex for individuals to transfer to appropriate services. Integrated care pathways need to be transparent and easy to access the first, and every, time a patient needs them.**

**Diane Hackney, a mental health service user on the need for integration :**

*"...one of the big problems is that every time we go anywhere we have to go through our entire history - and when we're talking of twenty or thirty years within the psychiatric system let alone in the health system generally, that takes a long time. If you've got a thirty minute consultation, twenty minutes of that's going over your history."*

3.11. However, they stressed that some patients will not have the knowledge nor the capacity to access services by themselves and will need the help of their GP to navigate the system.

3.12. The service users felt that there should be one care professional who takes responsibility for organising the patient's physical, mental and social care services. GPs traditionally hold this position in health care, but social workers or community nurses are often the first port of call for many. Having one designated support worker would help people to alleviate some of the most common referral problems and respond to the way in which people present a complex mix of physical, psychological and social issues to their GPs.

3.13. Care Services Minister Paul Burstow MP acknowledged many of the concerns, and stated that the government is working hard to ensure that there is integration across care pathways in the new system. The new Health and Wellbeing Boards have been set up with a leadership role at a local level and have duties to promote integration across local services. CCGs also have a

duty on them to ensure they actively encourage patient participation in deciding commissioning needs and commission services that integrate the needs of service users.

### **Integrating mental and physical health services**

3.14. **People with severe mental illnesses die on average 20 years earlier than the general population<sup>5</sup>, mostly due to preventable physical health problems. Having a mental health problem increases mortality from heart disease, and increases the likelihood of heavy smoking, drug and alcohol misuse and poor diet<sup>6</sup>. This may be because mental health is treated on a separate track to physical health, meaning that a person's physical health needs are ignored.**

- 3.15. MPs, Peers and panel members throughout the course of the inquiry voiced support for an amendment to the Health and Social Care Bill which would promote parity between mental and physical health. As a result, the final Act imparts a duty on the Secretary of State for Health to promote a health service that secures improvements in the prevention, diagnosis and treatment of physical and mental illness. It is hoped that this will not only lead to better and increasing quality in mental health services, but will also lead to improvements in the physical health of people with mental health problems.
- 3.16. Discussions about how this duty should be implemented are ongoing, but it is clear from the views expressed by service users and health professionals that there must be increased cross checking when primary and secondary health care professionals carry out medical assessments. They felt that professionals (such as GPs) should regularly undertake general checks for mental health problems when a person presents to them with a physical problems, and vice versa. However, attempts to identify co-existing health problems would only work if patients could then be referred to integrated services catering for the whole person.

# 4. Patient Choice and Personalisation

4.1. The principle of 'No decision about me, without me' underpins the reform of the NHS system. The coalition government wants to place patients' individual needs and wishes at the heart of clinical decision making. Importantly, the Health and Social Care Act 2012 contains a stand alone duty to promote involvement in patients' decisions about their own treatment. Through encouraging patients to share in decisions about their care, services will become increasingly responsive to individual patient needs.

## **Improving choice for people with mental health conditions**

4.2. **People with mental health problems typically have less choice of services; control over the kind of support they receive; and access to fewer opportunities to influence their care options than people with other health conditions.**

4.3. Service users said it was essential that reforms lead to greater choice and control for people with mental health problems, and their families and carers. People must be made aware of what support and services are available through better signposting from health

care professionals. They should also be able to plan, with support, their own individual care pathway according to their needs and capacity. Extra guidance and support must be provided to patients who lack the knowledge, capacity or skills necessary to be able to determine their own care pathway.

## **Personalisation**

4.4. **Panel members advocated the use of individual budgets - an allocation of money that people can use to purchase social care services of their own choosing - as a positive tool for increasing choice and control. Individual budgets represent a real opportunity to give people with mental health conditions increased choice and control over the support they receive, and enable people to be creative in accessing a wide range of social care services.**

*Paul Burstow MP, Minister for Care Services, emphasised the role of Personal Health Budgets in making 'No decision about me, without me' a reality:*

*"[personal health budgets are] I think potentially very powerful for driving change in the way in which services are commissioned, by effectively giving a lot more of the responsibility – with support – to the individual, because they're the ones who are saying "this is what's right for me in terms of meeting my health needs"... People who for years have been banging their heads against brick walls trying to get services to organise themselves around their lives are suddenly – because they're effectively holding the budget – feeling much more able to make that happen."*

- 4.5. It is a positive step that personal health budgets are being piloted within certain local areas, which will enable people to also purchase health services of their choice. But there was concern expressed that there is often confusion surrounding the nature of this initiative. As personal health budgets are rolled out, people will need to be able to access clear and standardised information about who to ask if they want to apply, and where that can receive advice and support on how to spend their budget.
- 4.6. There must also be recognition that money to fund personal budgets will be taken from the block contracts that many voluntary sector organisations rely on for funding. Representative from these organisations said they may not be able to continue offering a full range of services if block contracts were withdrawn, as they provide a degree of financial stability that is not offered through the personal payments model. This could have knock-on implications to the quality of local service provision.



All Party Parliamentary Group on Mental Health

The secretariat for the All Party Parliamentary Group on Mental Health is provided by:

