Funding for Mental Health Services: Is there 'Parity of esteem'?

Introduction

The North Central London Joint Health Overview and Scrutiny Committee have invited Barnet, Enfield & Haringey Mental Health Trust, C&I and their respective commissioners to submit a report on funding for mental health services to their committee on 7th February 2014. This follows concerns across the NHS about 'Parity of Esteem' in funding for mental health services. The government policy for mental health services has emphasised that there should be a 'parity of esteem' for mental health services and it should not be considered a poor relation to physical health services.

What health needs and services are covered by BEH and C&I?

Whilst many people use the term mental health services the general public often have different ideas about what this means. As in the rest of health care the portfolio of provision within each Trust are different. The following table provides a brief summary of the portfolios of the two Trusts:

Area	Brief Descriptor	BEH provides	C&I provides
Urgent & acute care	Home treatment and inpatient care for people with variety of mental health needs	√	√
Psychosis	Services for people with schizophrenia and bipolar disorder	√	√
Complex Psychological conditions	Severe depression, eating disorders, personality disorders, post-traumatic stress, obsessive compulsive disorder etc (portfolios	√	√

	different between Trusts eg BEH has eating disorders, C&I have trauma services)		
Cognitive impairment	Dementia	√	√
Forensic	Secure provision for people who have also committed an offence and who have a mental illness	√	**X**
Common mental health conditions	Moderate anxiety, depression, simple phobias (provided by IAPT services)	√	√
Child & Adolescent MH services	Services for children and adolescents	√	**X**
Substance Misuse	Treatment of addictions for people with alcohol problems and substance misuse	**X**	√
Learning disabilities	Mental Health specialist services for people with a learning disability	**X**	√

For a number of services such as Forensic or eating disorders C&I service users are referred to BEH services as they require a larger population base to provide a viable service. Some specialist services are duplicated.

In the past 4-5 years the range of mental health services have been extended through the development of:

- IAPT services, which now provide treatments to thousands of people who suffer from common mental health conditions, for whom there was no provision previously.
- Memory Clinics, to diagnose dementia (evidence suggests that early detection, reduces later crises and delays admission to care services) plus other new dementia associated services.

- Autism/ Asperger's services diagnostic

Commissioners have provided additional resources in these areas. In addition over many years there has been pressure on forensic services which have increased expenditure in this area. Commissioners have also funded specific developments within the 'core' portfolio, such as a recently opened Crisis House in Camden.

Key points:

- **BEH and C&I both have a common range of 'core' mental health services, but have different portfolios.**
- **Commissioners have increased the range of services through funding new services in areas where there has been no provision to meet mental health needs.**

Demographic pressures in north central London

Over the recent past the populations of all 5 boroughs have increased, creating additional demand for health and other public services. The mental health needs have also shifted, there appears to be a movement west to east across London and an extension from inner to outer London as low and middle income families cannot afford some inner London boroughs. Islington now has a greater mental health need than Camden (10 years ago it was the reverse) and there has been a significant increase in needs in Haringey and Enfield. A weighted mental health population shows the equivalent of current population served if the mental health need was average for England. The mental health needs for both Trusts are very high, with the highest need levels in Islington, Haringey and Camden.

Area	Population	Mental health weighted population	MHWP/ Population
Camden	220,300	383,719	74%
Islington	206,200	410,405	99%
Total C&I	426,500	794,124	86%

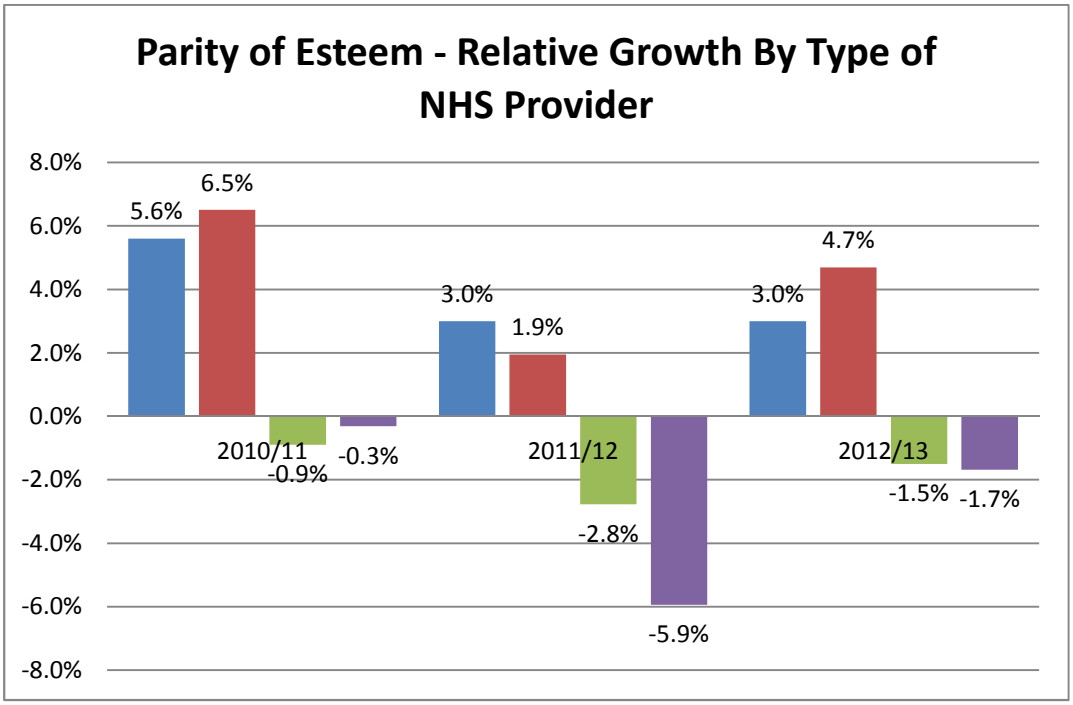
Haringey	254,900	359,399	41%
Enfield	312,400	356,369	14%
Barnet	356,400	381,604	7%
Total BEH	923,700	1,097,373	19%
Total NCL	1,350,200	1,891,497	40%

Figures from the Department of Health PRAMH model used to estimate MH need in the capitation formula

Key Point:

- **The mental health needs for both Trusts are very high.**

Relative income changes by year across North Central London



Acute Trusts are UCLH, RFH, Whittington (exc. community), North Middlesex & BCF.
Mental Health Trusts are C&I, BEH, SLAM, WL, NELFT (exe. community)

The chart shows over the period acute trust growth has always been positive in cash terms while the mental health trusts (with community) have always been negative. The real gap between acute providers and mental health Trusts is 4 to 7% a year. This is enormous. UCLH (+£143M = +21%) and RFH (+£73M =+14%) have been huge winners over the period 2009/10 to 2012/13. Whilst UCLH and RFH have had significant growth all the acute trusts have seen positive cash growth, whilst mental health trusts have shrunk over the period.

It is very clear that despite demographic and other pressures the relative resources for mental health services have reduced in real terms, whilst those for acute have increased significantly. Nationally, the resources for mental health reduced by 2% in real terms in 2012/13, despite the fact that mental health disorders have the highest prevalence of any condition as a group affecting 25% of the population. The lack of available treatment creates significant pressures for primary care and other parts of the public sector.

Unlike acute trusts mental health services have always been funded on the basis of block contracts, this means that funding is adjusted each year by applying the national cost of living increases and a reduction for efficiency. There is no automatic mechanism to fund additional need due to population growth or a change in the need profile of a borough in mental health services.

The picture of overall reduced income is despite the additional funding for services developments. Mental health trusts have therefore had to deliver significant efficiency programmes which they have, for the most part done very successfully for many years. Most acute Trusts have delivered significant proportions of their annual efficiency targets through the financial contribution made by their growth. The surplus component of activity growth plus the difference between marginal and full costs has enabled then to shield operational services from productivity and efficiency requirements. Monitor estimates that at best acute providers have delivered 2% efficiency per year.

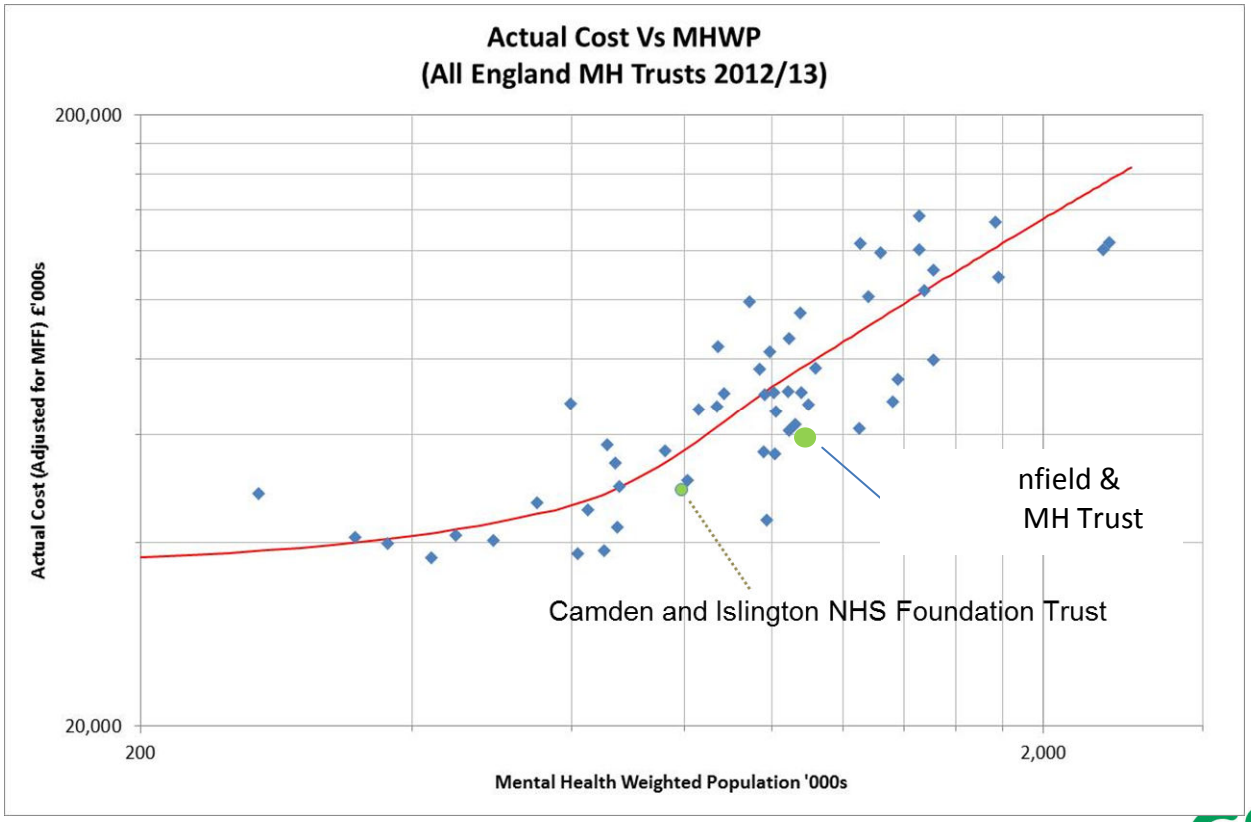
In the national guidance for payment in 2014/15 released in December 2013, the DH and Monitor required an additional 0.3% efficiency from mental health and community providers than acute Trusts. This is currently being challenged as there is no logic to this additional requirement.

Key Points:

- **There have been increased resources to Commissioners**
- **Acute Trusts have had significant growth**
- **Mental Health Trusts have had reduced income despite some developments and the highest health burden**

BEH and C&I Trusts relative efficiency

It could potentially be the case that both mental health trusts are inefficient. The chart below shows the correlation between the mental health weighted



population (MHWP) for Trusts and the reference costs for adult services (adjusted for market forces factor/ high cost areas and excludes specialist services, substance misuse etc)). There is a strong correlation between costs and weighted population served.

Both mental health trusts have lower reference costs relative to MHWP compared to the trend demonstrating efficient provision compared to other MH Trusts.

The chart also examines economies' of scale in mental health provision. Trusts which provide services below 1million MHWP have diseconomies of scale, whilst those above 1.5million MHWP appear to have economies of scale, with the except of those in rural areas with challenging transport networks.

Key Point:

Both Trusts are efficient providers

C&I efficiency programmes

Over the past few years C&I have delivered significant levels efficiency in the years from 2010-11, the Trust delivered:

2012/13	£7.3m
2011/12	£12.1m
2010/11	£3.7m
Total	£23.1m

This is 17% of initial turnover (2009/10 turnover was £137,954k). In 2013/14 we have a further efficiency requirement of £4.9m

The scale of change this required to deliver this has been extensive. In 2011/12 we delivered more than the previous 3 years' worth of efficiencies in one year. The scale required in 2011/12 and subsequent years meant that we decided to completely redesign services rather than take a 'salami slice' approach. Building on the clinical strategy we have aligned all services into care pathways focusing on recovery. Within this we have created a single point of entry for non-urgent care in each borough, created

new models for complex psychological disorders, adopted best international practice for our assertive outreach services and developed new structures for people with long term psychoses to promote personalization and recovery. In urgent care, we redesigned the care pathway introducing an assessment ward, including recently piloting Sunday ward rounds, and have significantly reduced average length of stay. The new Camden Crisis house adds another welcome alternative to inpatient admission for service users.

During this period we have:

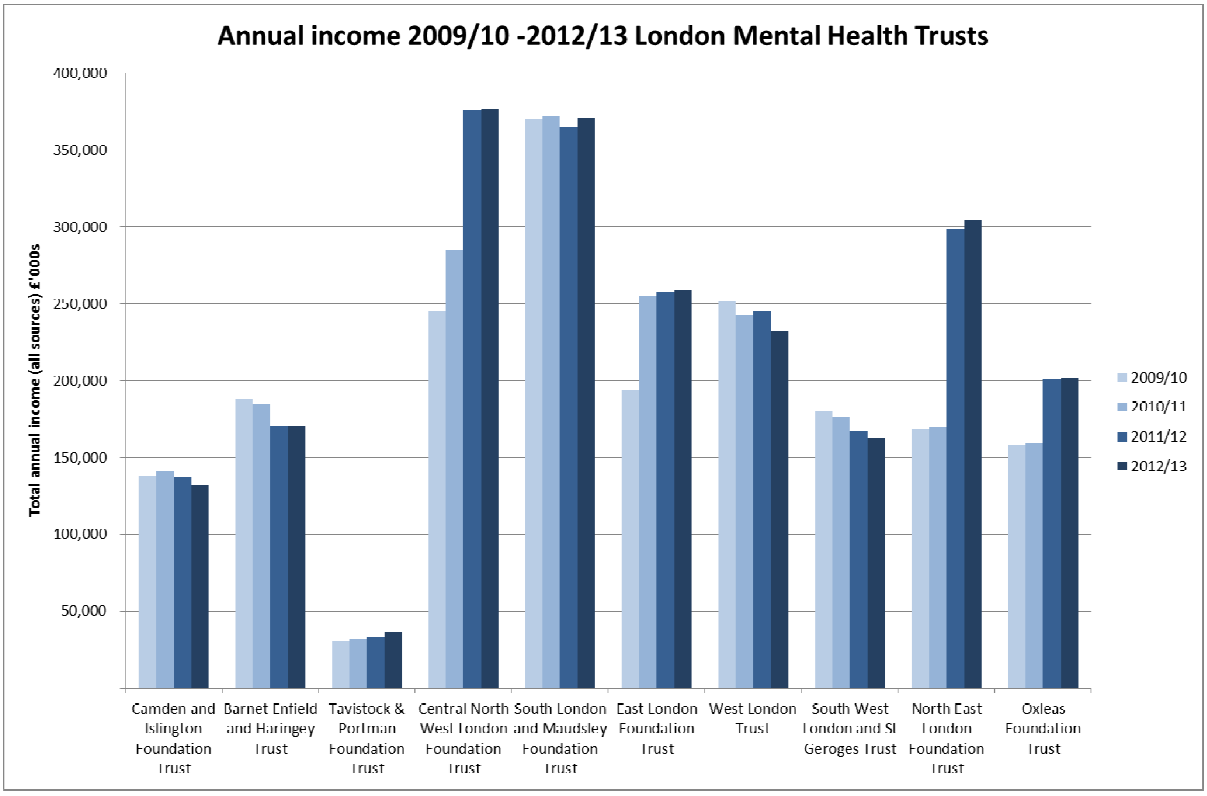
- Reduce acute inpatient bed capacity by 31%;
- Reduce our total estate by 25%, including reducing our acute inpatient sites from 4 to 2;
- Market tested and renegotiated most corporate and contracted services including catering, property maintenance, laundry, estate management, staff bank, pharmacy, transport etc;
- Working with commissioners brought back many high cost individuals to local services.
- Through consolidation of teams and senior staff reductions reduced the number of managerial posts by 40%;
- Completely reconfigured our community services along care pathways implementing new models of working, and reduced the average workforce grades.
- Sold St Luke's Hospital, which eliminated capital and other revenue costs

Key Point:

- **C&I has fundamentally redesigned its services in response to efficiency requirement and made substantial savings over the period.**

Wendy Wallace
Chief Executive
January 2014

Appendix



Where there are significant increases in funding in 2011/12 this is due to the acquisition of community services. The only Trust who did acquire community services and there is no evident increase is BEH, who acquired Enfield Community services, but had other reductions.