RADIX

VOLUME FIVE

PROFESSOR STEPHEN K SMITH

Managing the Mental Health Crisis

The Best NHS?

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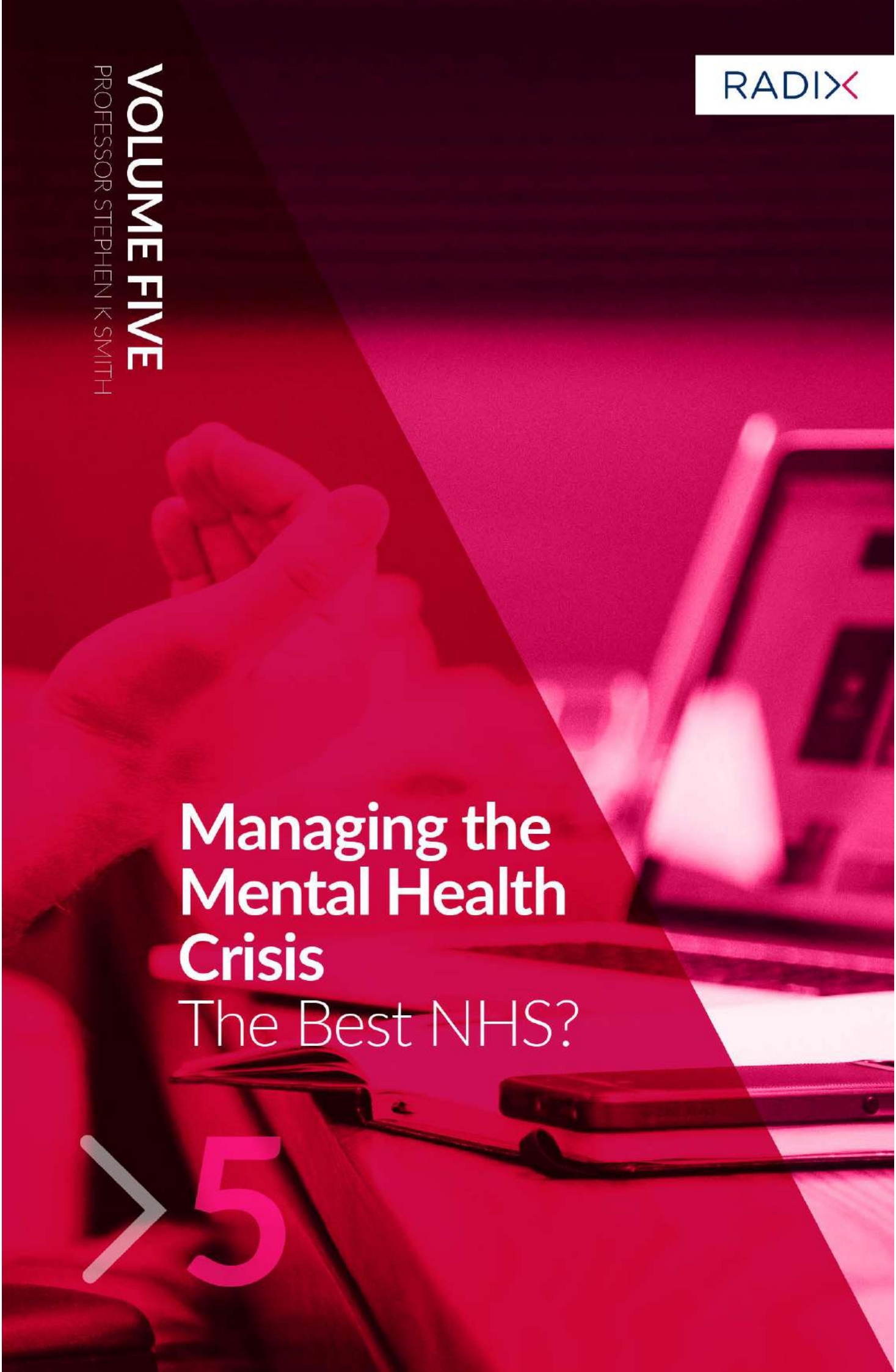


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Managing the Mental Health Crisis

The Best NHS?

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SUMMARY

The message needs to go out to politicians and the public that hospitals and the broader healthcare economy are difficult entities to manage, and good, well-supported managers are vital to delivering safe and effective healthcare. Managers need to complete, as they take on more responsibility, a medical MBA that teaches them advanced management techniques. The courses need to be stimulated in existing universities where competition between them – the type of competition that has made British bio-medical science world-class, spurred by competition between universities like Oxford, Imperial and Cambridge and their international counterparts – creates innovation and adaptation. This is not a task for a centralised NHS or government-run programme. There have been many such failed state-driven initiatives in the past, undermined by political game-playing and civil service amateurism.

We believe that the morale and motivation of NHS managers has been fatally undermined by focusing on process targets. This is compounded by a regulator, the CQC, that seeks out (universally unintended) clinical error so that it can apportion blame and, in many cases, bring about criminal prosecutions. The authors point to the damaging effects that this combination of poor management and predatory regulation has produced:

- *Morale and motivation of NHS professionals is low. This is not a Covid effect. It has been endemic in the NHS for years.*
- *Improved efficiency is outweighed by the cost of the elaborate and bureaucratic systems needed to enforce and measure compliance with process targets.*
- *Professionals forced to work to process targets are not only demotivated, they make more errors. The NHS receives 10,000 new claims for compensation every year. The total cost of outstanding compensation claims is estimated at £83 billion (compared to an annual budget of some £130 billion for NHS England).*
- *The UK system delivers worse outcomes for patients than comparable health systems elsewhere.*

Professionals are, after all, what health and care is all about. No-one wants a manager, whatever career or which business school attended, to operate on their brain. But in order to make the health and care service both clinically excellent and efficient in terms of treating more patients and spending taxpayers money wisely, clinicians and managers need to become better informed and more respectful of what each brings to the critical task of improving the health and ***wellbeing*** of the UK's population.

The pressure on the system is apparent in all of the five major health and care domains:

- **MENTAL HEALTH**
- **COMMUNITY-BASED CARE**
- **PRIMARY CARE SERVICES**
- **A&E AND THE EMERGENCY PATHWAY**
- **IN-HOSPITAL SPECIALITIES**

MENTAL HEALTH

Future books will describe the reforms required to improve the last four of these domains. This book discusses the reforms required to improve the UK's care for those with mental health conditions. These are:

- *Take sustained action within the Integrated Care Systems, with appropriate funding to match the good intentions.*
- *Manage joined up care pathways over full cycles of care for those with a mental health condition (as part of a High-Risk-Care-Management programme).*
- *Pay particular attention to children and adolescent mental health services (CAMHS) to stop vulnerable people 'bouncing' in and out of mental hospitals, and an end to the harsh cliff-edge as CAMHS services are withdrawn when a person turns 18. Interventions in the early years have a disproportionate effect to the long-term health of individuals.*
- *Deliver on the pledge for more resources in community care, and extend the scope of attention into problem families and the criminal justice system.*
- *Invest in the workforce and encourage respect.*

The Integrated Care Systems are an opportunity to finally put mental health on an equal footing with physical illness – and to recognise that they are intimately linked. Spending on mental health, the evidence shows, will reduce spending on physical illness, and ICSs are the channel for making these integrated spending decisions. Better integrated management of physical and mental health is cost efficient. More importantly, it can have a significant and positive impact on the individual's quality of life.

Better management of the five health and care domains

SECTION 1

The NHS and social care need better supported management and clinicians.

They operate in a complex environment.

Managing in the health and care sector is not easy.

> *'However much governments or others increase their spending, it never seems to be enough. In almost every other area of the economy, productivity is rising and costs are falling through competition and innovation. We have better, faster, cheaper computers, cars, consumer goods, food, banking and so on, yet healthcare costs are stubbornly high and continue to rise.*
>
> *'In short, the social, political and economic context in which healthcare organisations have to exist is often a hostile, fast-changing and pressured environment. Managers and leaders strive to balance competing, shifting and irreconcilable demands from a wide range of stakeholders and do so while under close public scrutiny. The task of leadership in healthcare organisations — defining the mission of the organisation, setting out a clear and consistent vision, guiding and incentivising the organisation towards its objectives, and ensuring safe and high-quality care is made much more challenging by the social, economic and political context in which they work.*[1]

Managing a hospital, especially, is not easy. There are many more complex 'process' industries in the world: making the parts for, and assembling an aircraft, for instance is mind-bogglingly difficult ***('an Airbus A380 is made up of about four million individual parts produced by 1,500 companies from 30 countries around the world).'***[2] But the peculiar combination of a very people intensive environment (70 per cent of a hospital's costs are people, all of them working under pressure), patients who are ill and inevitably stressed, friends and families visiting at all hours, all create an intensely busy environment - King's College Hospital, for instance, treats 1.4 million outpatients a year. In addition, intense scrutiny from regulators, the NHS hierarchy, politicians and the press (both local and national) make hospital management particularly challenging. The pressure on managers is always intense, often unfair and unrelenting.

Moreover, a healthcare system is especially difficult to manage because it is a system in which all the parts interact and influence each other. For example, error and harm to patients that elicits a punitive response from the regulator, CQC, will build a culture of blame and fear which results in the cover up of mistakes and a lack of learning, which in turn... leads to error and harm to patients. Another example is that the biggest system effect – a core part of this book series – is that cuts in social care result in increased pressure and cost in healthcare (the NHS) which then drives further cuts in social care.

And, like any complex system, the health and care system exhibits what physicists call 'entropy': a thermodynamic quantity representing the unavailability of a system's thermal energy for conversion into mechanical work, often interpreted as the degree of disorder or randomness in the system. In short, it is very prone to chaos and without constant and expert attention, it unravels very quickly.

The world of day-to-day NHS practice can seem a distant series of events for a secretary of state or an NHSE/I senior team. The billions of transactions between patients and clinicians can seem like a pulsating carpet of tiny ants. But politicians and senior managers need to get close to what is happening on the ground not just by making regular visits to hospitals and out of hospital operations, but by having a deep understanding of what the key processes are, and both how they can be fixed and what unintended consequences can result from high-level decisions.

The managerial strain is compounded by an often rancorous attitude towards management which is often equated with bureaucracy or unproductive overhead and the service is chronically underfunded.

> *"Health Foundation analysis shows maintaining current standards of care requires overall funding to increase by at least 3.4 per cent a year – an extra £2bn of funding above current spending pledges. To improve standards and transform services it said the health service needed 4.1 per cent of extra spending – equivalent to £6bn more spending than promised by ministers. This spending also does not address the social care crisis where restoring budgets to 2010 levels would require £12bn of extra spending."*[3]

The message needs to go out to politicians and the public that hospitals and the broader healthcare economy are difficult entities to manage, and good, well-supported managers are vital to delivering safe and effective healthcare.

MANAGEMENT QUALITY IS GENERALLY POOR IN THE NHS

Leadership in the NHS, especially at the hospital level, is problematic. The generally poor quality of management has been mentioned, and so, too, the fact that they are woefully under-supported and under-resourced. This failure of management can result in clinician disengagement. Clinicians still look after their patients, but sometimes they focus just on the patient in front of them, and do not get fully involved in the broader management task, having been let down, as they see it, so often and so badly in the past. For example, surgeons no longer manage their operating lists. This is now undertaken by a 'theatre list management team', divorced from the patients resulting in theatre utilisation far inferior to that achieved in the private sector and incapable of resolving the 'waiting list crisis'. It leads to disengagement by the surgeons who - if given the authority and the reinstatement of the ability to manage their clinical team - would significantly increase both the efficiency and the safety of the NHS.

Decisive, competent leadership, both clinician and managerial and with clear executive authority, is a prerequisite to achieving the reforms outlined in this book.

> *"'It has been established that effective leadership is required to facilitate integrated care. This is clearly felt by doctors: when asked to identify the barriers to achieving integration through joined-up care pathways, over half of doctors responding to our survey felt that a lack of managerial leadership was a key barrier. Almost 44 per cent identified lack of clinical leadership as a barrier."* [4]

Supporting management and developing them, on the one hand, and re-engaging clinicians on the other is a key element of the turnaround of the health and care system. More clinicians need to be induced into management, and non-clinician managers need to be better educated and better induced into the clinician perspective.

EDUCATING AND DEVELOPING MANAGEMENT SKILL AND TECHNIQUE

There are incipient health management courses at some UK universities, such as Imperial and Warwick, but Corporate NHS has to invest with them and support them in developing 'Medical MBAs'. These MBAs would teach advanced techniques in management, techniques that are sorely lacking in an NHS management clique that has been hermetically sealed off from the private sector, where competition has stimulated innovation and efficiency.

The MBA, and its sub-modules for shorter duration courses, would be aimed at clinicians who want to make the transition to managerial roles, and to non-clinician managers who want to deepen and broaden their skill set. Core elements of the Medical MBA would comprise a 'general management' content, but would also include the effective management of the key processes within hospitals and the broader healthcare economy. Four of these are examined in more detail in following books in the Radix series (the first, better management of mental health, comprises the second part of this book) and would be core modules in the Medical MBA. Such courses must have a curriculum and be part of a coherent educational strategy and must not be a series of disconnected modules provided only online.

European countries tend to have many more clinicians who have gone into healthcare management, and they are better trained than UK NHS managers. However, poor quality management is not just a UK problem, as the extract from an article in the Harvard Business Review attests:

> *"Yet most doctors in the US aren't taught management skills in medical school. And they receive little on-the-job training to develop skills such as how to allocate short- and long-term resources, how to provide developmental feedback, or how to effectively handle conflict – leadership skills needed to run a vibrant business."*
>
> *"A popular way of bringing physicians up to speed is to elevate them into management roles and team them with business executives. But this approach, called the 'dyad model' is not an optimal long-term solution…. Rather, I suggest a different approach: carving out a career path for younger physicians with leadership potential and creating a well-designed development pipeline so doctors emerge able to effectively lead large organisations of medical providers."*[5]

In the same article, the authors chart out a career path for doctors within their hospitals. Although this refers to a US system, it is relevant to the UK.

> *'This pipeline moves physicians through five levels of leadership – each allowing them to take on greater responsibility and gain the experience and skills necessary for succeeding at the next level. Over time, they develop the capacity to lead beyond the clinical enterprise and a more holistic view of the organisation's needs.'*

'Each level involves a specific focus and set of skills:

***Individual practitioner:** This level comprises practicing physicians who are part of a practice, group, or solo private practice and are focused primarily on patient care. Technical proficiency is valued most in this individual contributor role.*

***MD leader:** This level involves running a medical group, hospital programme, or an academic medical center (AMC) division (as a medical director of a service line or group of MDs, or a leader of a clinic or residents/fellow programme in AMC) and managing other physicians or a programme. These leaders learn to oversee and delegate work, and develop and coach others. Emotional intelligence is an important skill to develop at this level.*

***Market MD leader:** This role is responsible for a business segment or region, and oversees other MD leaders or a broader scope of clinical/ MD staff (such as regional or market physician leader or chief of an AMC faculty division). This is where you often see dyad models emerge, as the role involves both clinical oversight and greater business responsibilities. The leader must learn how to manage financials, develop a longer-term view, and build knowledge of how to devise strategy. Communication and collaboration skills are paramount.*

***Group MD leader:** This role oversees a group of businesses, often as group president or chief medical officer for a corporation or chair of an AMC faculty department, with responsibility often expanded to include both clinical and business outcomes. Here the leader must be proficient in evaluating strategy, portfolio assessment, and factoring in the complexities of both internal and external business requirements, in addition to the skills gained in prior roles.*

***Enterprise MD leader:** This top leadership role, such as Director of an AMC or CEO, is responsible for an entire enterprise, including its strategic direction and overall organisational results. Leaders at this level emphasize visionary thinking, discerning key external trends, strategic positioning, and developing mission-critical priorities.*

At each level, the mix of strategic, business, relational and clinical skills required to lead is quite different."

The Skills Physician Leaders Need at Different Stages of Their Career

Greater leadership responsibilities demand a shift in skills.

SOURCE FMG LEADING

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MANAGEMENT SKILLS [6]

The investment in management education could be self-financing if one of the stated objectives was to phase out the use of expensive business consultants and to replace them with a new and professional medical management cadre. The King's Fund has drawn on a local example of management education to make this point:

> *"The South Central high potential leaders programme suggested that raising the skills of senior staff allowed them to take on tasks usually outsourced to expensive external consultancies, while reducing staff turnover and increasing job satisfaction. Despite a £3 million investment – a figure that included the indirect costs of time lost through participation, as well as direct costs – organisations had only to reduce their use of external consultancy by 10 per cent a year, and have staff stay in post for an additional six months, for the investment to be recouped. The study suggests that high quality care is in fact cheaper, or at the very least cost neutral, and that developing staff is not a luxury but a necessity for good patient care."* [7]

The route to 'minting' these Medical MBAs is crucial. The courses need to be stimulated in existing universities where competition between them – the type of competition that has made British bio-medical science world-class, spurred by competition between universities like Oxford, Imperial and Cambridge and their international counterparts – creates innovation and adaptation. This is not a task for a centralised, NHS or government-run programme. There have been many such failed state-driven initiatives in the past, undermined by political game-playing and civil service amateurism. The much-heralded 'NHS University', for instance, was set up in December 2003 and lasted less than a year.

A historical footnote is appropriate here as it illustrates the point that many of the problems in the NHS and social care are well-known, but that the problem is that changes are never implemented. The poverty of management and the lack of clinician engagement was identified in the Griffith Review of 1983. Sensible recommendations were to professionalise management and to induce clinicians into the managerial function – both in terms of harmonising their clinical practice with a manager's quest for efficiency and effectiveness, and also for more clinicians to become those very same managers. Thirty-nine years later, the problems have become worse not better.[8]

MANAGING CLINICIANS

Managing clinicians, especially doctors, is not easy either. They can be headstrong and defensive – and they can also be very eloquent in defending their defensiveness. There are four principles that managers, both clinician and non-clinician, should follow in working with doctors, senior nurses and other healthcare professionals:

1. **Listen to them and respect their views.** They are not only on the frontline but medicine is a professional service and they are the only professionals (except in very controlled circumstances) who know about the clinical condition of the individual patient and what treatment or management is required. When applied to the service they are thus uniquely in a position to know where the problems and inefficiencies lie and, of greater importance, to know about the potential harmful consequences for patients if the drivers of economy or efficiency would lead to harm to patients. It is true in every sector of industry, that people like to be listened to but in 'medicine' decisions as to the application of clinical services to patients is decided only by the doctor.

2. **Involve them.** It is also true in every sector of the economy that people, at all levels, want to be involved in designing the way that their job is structured. The conundrum for all health services is how do you do that in highly complex organisations like a hospital. There are two issues, the first is strictly clinical and the second more organisational. The management of medical conditions is not stipulated by some central organisation, rather it is the result of a wide variety of experiences including medical research, clinical trials, personal preferences and many more. The way in which one surgeon actually performs a hip replacement will vary slightly from individual to different hospitals though they do comply with a loose broadly agreed criteria. For non-specialist care this is usually more uniform but for very specialist care it will almost always be tailored to an individual patient. The organisational part is still difficult as it requires the closest relationship between the clinicians who are in effect, deciding what care and resources need to be employed and the manager who is there to provide the necessary support in order for that care to be administered as efficiently and cost effectively as possible.

'More diffuse styles of leadership underline the point that the NHS needs strong leadership and management 'from the ward to the board'. Clearly, managers require development and support but there is mounting evidence that where doctors and nurses and other health professionals are provided with clear information about costs, along with the authority to tackle them – for example, through service line reporting in hospitals or prescribing costs in general practice – higher quality and better care results. This has been demonstrated both in the NHS and in reviews of evidence from the experience of health care systems in other countries (Ham 2003; Ham and Dickinson, 2008). It is the commission's firmly held view that one of the defining weaknesses of the NHS over the decades has been the lack of involvement of clinicians in management when it is the decisions of clinicians – in particular doctors – that chiefly influence how the budget is spent. From Cogwheel to Griffiths to the current work of Sir Bruce Keogh, the NHS medical director, the importance of this has been regularly recognised. But there have been many reverses.' [9]

3. **Use data.** Doctors are trained in science, and they respect and feel comfortable with data. In the experience at King's, there was a lot of talk about evidence-based medicine, but when it came to management, too many decisions were taken without evidence, or at least without the evidence being open and discussable. This lack of managerial rigour is, of course, recognised by clinicians and adds to the disregard that many clinicians feel for management.

   Re-engaging doctors is done by demonstrating evidence-based management, but this isn't as easy as it sounds. Management skills are poor in the NHS, and a core management skill is good analysis and the numeracy competence to back it up. These are in short supply in the NHS. Even those who entered the 'finance and control' function in NHS management rarely progress beyond a basic accounting perspective.

   The motivations for many to enter NHS management is 'public service' or 'doing good', and whilst these are admirable qualities, they sometimes come at the expense of good analytical abilities. Having made this claim, however, there is no hard evidence to back it up. It could be that the people who enter NHS management have the same basic capabilities as those in the private sector, but they are just not developed into advanced techniques because of the poor management support available.

4. **Tackle the performance gap,** and this was illustrated in all five of the key process management areas – the 'emergency pathway'; hospital discharge management and community-based care, 'productivity' in specialities (and the data-driven GIRFT Getting it Right First Time process in orthopaedics is the 'exception that proves the rule'); management of mental health; and management of the out-of-hospital environment – described in the following books, drawing on the author's experience managing hospitals. Whichever view is right, and it's probably a combination of both, better management support, development and education are essential priorities for the future. Though it must be remembered that organising orthopaedic services is simple compared to the complex management of many other non-surgical conditions;

Finally, relate all decisions and actions back to the patient, and how it improves things for them. Clinicians came into the medical, nursing and caring professions because they care about patients. Therefore, the patient must become the central plank of any management action.

These four approaches are the positive aspects of managing clinicians. To use a cricketing analogy, this style of management 'hits with the spin'. But there are also bad habits in the clinician-management relationship that require wholesale changes in technique. Clinicians, as my brother found at King's, are great people but they have very inbred instincts that confound management of the five key clinical domains. These instincts are (with verbatim quotes from King's):

- *'I was taught at medical school to care for patients not to manage 'quotas' or fill in time-sheets. You can try to move patients on through the system, but I am not going to compromise my care training. I am not a queue-buster, and an administrator bawling at me is going to make no difference whatsoever (and he/she is not a clinician anyway') and again 'my job is not to discharge this patient quickly….it is to make sure they are safe.'*
- *'I am an individual and my moral code is more important than any top-down targets. I don't give a flying f*** about the four hour target – I care for the patient in front of me. If someone has a bloody nose, and I am saving a Road Traffic Accident (RTA) victim, then they can bloody well wait.'*

- *'I am articulate and well educated and highly trained – you had better treat me with respect, give me scientific data on why I should behave differently ('I am saving lives'). You have left school with a string of 'O' levels.'*

Managers are also often overwhelmed by the complexity and the difficulty of getting things done – they are told just to hunker down.

The NHS (and social care more broadly) also generates very cliquey environments which are relationship-based, which makes performance management difficult. It can also be a somewhat bitchy environment, exacerbated by large numbers of people (health and care is very labour intensive and nearly always working under stress). This leads to the most complained aspect of NHS care for the patient which is, 'nobody seems to be in control?' The answer is that nobody is in control. Once the patient moves to the hospital or needs social care, a totally different hierarchical organisation takes control which does not communicate at the operational level with each other.

This can also engender a Masada complex which becomes both defensive (a problem when the aspiration is for a 'learning culture') and, at the same time, quite aggressive towards the out-group, whoever that might be.

Discipline and performance management is difficult. When relationships break down and people get stressed, they make complaints to HR (a rather risk averse, overly sensitive function, understandably reluctant to stray from strict 'process rules' to avoid censure) about harassment and seek sick leave which lasts for months and sometimes years (on full pay, which constrains permanent replacement appointments).

These often poor quality management environments have resulted in disillusionment and resentment in many parts of the clinical community who are resigned to not being allowed to be in charge thus unable to improve the service and they along with the patients just suffer the inefficient service. In one Trust, operating times did not start on time in 75 percent of cases, which the surgeons were powerless to change. The nature of the disaffection varies somewhat between nurses and doctors. For nurses, there is a sense of being undervalued, not so much by doctors (although there is some of that) and the public, but rather by the government. This has been made worse during the pandemic, as in this report in the Financial Times ('Maggy' is a disguised name for a nurse interviewed by the FT):

"We're totally undervalued by the government," Maggy said, pointing to the struggle to secure personal protective equipment to protect her vulnerable clients in the early weeks of the pandemic. A proposal from ministers earlier this year that nurses should receive a pay rise of just one per cent had been "the last straw", she added. She is not alone in having second thoughts about a career in the UK health service. Last month the Nursing and Midwifery Council, the profession's regulator, warned that while 15,000 more nurses, midwives and nursing associates were now registered compared with March 2020, "the rate of growth has slowed and the longer term impact of Covid-19 on a workforce under increasing pressure is a clear concern." [10]

For doctors, the concern is more that their professionalism is being undermined by a mechanistic approach to management, both by the government and by NHS managers both centrally and locally. An important objective in improving the health and care system in the UK is to give voice and responsibility back to doctors. In the first of the next two sub-sections, I argue the case for recognising the unique professional qualifications and perspectives of doctors. In the second sub-section, we look at the blind spots that a doctor's perspective can display, and some of the challenges of managing doctors in particular, and professionals in general.

REHABILITATING CLINICIANS, ESPECIALLY DOCTORS: THE DOCTOR'S PERSPECTIVE

In a recent Radix paper written by myself and Dr Joe Zammit-Lucia, entitled ***The NHS is not a sausage factory***, we begin by lamenting the way that 'efficiency' rather than the 'patient' has become the central objective for NHS managers,[11] This drives an emphasis on meeting throughput targets – as in a factory; rather than focusing on the patient. We contrast this 'mass production' mentality with what really motivates doctors and what is really in the best interests of patients:

'Here are the characteristics that decades of research and experience have been shown to make for successful professional services organisations:

- *We need inspiring leadership, usually by peers, that motivates the professionals NOT process micromanagement that is both counter-productive and demotivating.*
- *The role of 'management' is to provide support and to make the resources available for the professionals to do their job NOT to tell everyone what to do and how to do it.*

- *They work best when organised as collaborative networks of small, semi-autonomous, self-directed units NOT through large, hierarchical, top-down organisational structures. Given this freedom at the start of the pandemic, clinicians rose to the task magnificently, only for the cold hand of bureaucracy to re-appear once the crisis declined.*
- *For professionals, motivation is intrinsic NOT extrinsic. In other words, the best professionals are attracted and motivated to give their all by the rewards inherent in 'a job well done' NOT by meeting extrinsic, management-imposed measures of efficiency.'* [12]

By focusing on process targets, we believe that NHS managers undermine these principles and that morale and motivation is, as a result, fatally undermined. This is compounded by a regulator, the CQC, that seeks out (universally unintended) clinical error so that it can apportion blame and, in many cases, bring about criminal prosecutions. They point to the damaging effects that this combination of poor management and predatory regulation has produced.

'The effects of the sausage factory mentality on the NHS – top-down hierarchical management systems, an overly large, centralised organisational mentality, forcing professionals to work to process goals, endless protocolisation – have been highly destructive:

- *Morale and motivation of NHS professionals is low. This is not a Covid effect. It has been endemic in the NHS for years.*
- *Improved efficiency is outweighed by the cost of the elaborate and bureaucratic systems needed to enforce and measure compliance with process targets.*
- *Professionals forced to work to process targets are not only demotivated, they make more errors. The NHS receives 10,000 new claims for compensation every year. The total cost of outstanding compensation claims is estimated at £83 billion (compared to an annual budget of some £130 billion for NHS England).*
- *The UK system delivers worse outcomes for patients than comparable health systems elsewhere.'* [13]

We ended our paper with recommendations of what needs to change.

- *The NHS needs more inspiring leadership and less process-focused micromanagement.*

- *We need to organise around small, self-directed clinical units with decision-making delegated to the frontline professionals.*

- *NHS management need extensive training in how to manage in a professional services organization. To realise that their role is one of enabling and supporting heath care professionals and to learn from them what is best for the patient. It is not to tell them what to do - because they don't know.*

- *The political class on both sides of the aisle need to search their souls and decide whether their aim is to improve NHS performance or whether the prime focus is the news shot in front of a useless Nightingale Hospital or to get a seemingly clever question in during PMQs.'*

A MANAGEMENT PERSPECTIVE

This book also draws on research by those who have had management careers spanning over 40 years, managed companies or organisations ranging from professional services firms (management consulting) to a FTSE 20 company, and those with management experience of the biggest care home organisation in the UK and one of the NHS' biggest and most complex hospitals (King's College Hospital). They agree with much of this diagnosis. A good manager – and to repeat, there are far too few good managers in the NHS – recognises the factors that motivate good performance (with 'patient value' at its core) and is very deliberate in creating the best environment for motivation, morale and performance to be maximised.

Even so, a manager has to manage **both** doctor morale **and** efficiency. This is not just an administrative target, it is a duty and responsibility. Patients want **both** good outcomes from their treatment **and** access to such treatment in an efficiently run system. The people who provide the money for the service – mostly taxpayers in the UK – want **both** a good service **and** to know that their hard-earned money is being spent efficiently.

This management perspective is not one that doctors, specifically, and professionals in general tend to be sympathetic to. There are a number of reasons for this.

The first is that professionals – doctors, but also lawyers, engineers, accountants, management consultants, and so on – are consumed by their professional education from a very early age (for doctors as young as 17 or 18). Their world view is shaped by their expertise, which is almost universally both task oriented and carried out in small group settings (a one-to-one GP consultation or even a complex operation involving, say, a team of 10 people in an operating theatre). So consuming is the skill required to carry out the task, that the broader context becomes blurred. This is not conducive to professionals seeing 'the bigger picture'.

Moreover, these professionals are very bright, by definition well-educated and highly articulate. They come to believe that their perspective – even their perspective of the 'bigger picture' – is gospel. Of course, with time, good managers can engage with doctors not only to outline the bigger picture but also participate with them in devising better solutions, combining the clinical and managerial perspectives, to make the 'bigger picture' prettier. Yet poor managers, especially in the hierarchical, blame-driven environment of the NHS tend not to invest the time required to achieve better, more integrated, outcomes.

Due to the exigencies of applying their professional skills to critical tasks - life and death in the case of doctors - they have never been schooled in management technique, and due to their 'bounded' training do not tend to have managerial skills. As a consequence, they view management as, at best, either a 'generic' skill that anyone can pick up or, at worst, obstructive bureaucracy.

A long career in the highly demanding world of advanced management, with a qualification from one of the top five or six business schools in the world, supplemented by ongoing technique development and skill development (with the 'sack' if high performance is not maintained) is not recognised by many doctors or lawyers etc. as commensurate with their qualifications.

An interesting implication of the intelligence of professionals is that, if not skillfully managed, they can be very defensive and 'closed to learning'. The inventor of the term 'the learning organisation', Professor Chris Argyris of the Harvard Business School, identified the paradox that it is the brightest people who find it most difficult to achieve organisation learning. His paper 'Teaching smart people how to learn' was based on his experience at a consulting company.[14] He wrote:

> *'Any company that aspires to succeed in the tougher business environment of [today] must first resolve a basic dilemma: success in the marketplace increasingly depends on learning, yet most people don't know how to learn. What's more, those members of the organization that many assume to be the best at learning are, in fact, not very good at it.*

I am talking about the well-educated, high-powered, high-commitment professionals who occupy key leadership positions in the modern corporation.

Most companies not only have tremendous difficulty addressing this learning dilemma; they aren't even aware that it exists. The reason: they misunderstand what learning is and how to bring it about. As a result, they tend to make two mistakes in their efforts to become a learning organisation.

First, most people define learning too narrowly as mere 'problem solving', so they focus on identifying and correcting errors in the external environment. Solving problems is important. But if learning is to persist, managers and employees must also look inward. They need to reflect critically on their own behaviour, identify the ways they often inadvertently contribute to the organisation's problems, and then change how they act. In particular, they must learn how the very way they go about defining and solving problems can be a source of problems in its own right.

I have coined the terms "single loop" and "double loop" learning to capture this crucial distinction. To give a simple analogy: a thermostat that automatically turns on the heat whenever the temperature in a room drops below 68 degrees is a good example of single-loop learning. A thermostat that could ask: ***"Why am I set at 68 degrees?"*** and then explore whether or not some other temperature might more economically achieve the goal of heating the room would be engaging in double-loop learning.

Highly skilled professionals are frequently very good at single-loop learning. After all, they have spent much of their lives acquiring academic credentials, mastering one or a number of intellectual disciplines, and applying those disciplines to solve real-world problems. But ironically, this very fact helps explain why professionals are often so bad at double-loop learning.

Put simply, because many professionals are almost always successful at what they do, they rarely experience failure. And because they have rarely failed, they have never learned how to learn from failure. So whenever their single-loop learning strategies go wrong, they become defensive, screen out criticism, and put the "blame" on anyone and everyone but themselves. In short, their ability to learn shuts down precisely at the moment they need it the most.

The propensity among professionals to behave defensively helps shed light on the second mistake that companies make about learning. The common assumption is that getting people to learn is largely a matter of motivation. When people have the right attitudes and commitment, learning automatically follows. So companies focus on creating new organisational structures—compensation programmes, performance reviews, corporate cultures, and the like—that are designed to create motivated and committed employees.

But effective double-loop learning is not simply a function of how people feel. It is a reflection of how they think—that is, the cognitive rules or reasoning they use to design and implement their actions. Think of these rules as a kind of "master programme" stored in the brain, governing all behaviour. Defensive reasoning can block learning even when the individual commitment to it is high, just as a computer program with hidden bugs can produce results exactly the opposite of what its designers had planned.

Companies can learn how to resolve the learning dilemma. What it takes is to make the ways managers and employees reason about their behaviour a focus of organisational learning and continuous improvement programs. Teaching people how to reason about their behaviour in new and more effective ways breaks down the defences that block learning.'

These principles of the 'learning organisation' are used in Book 10 to describe how the main UK regulator, the CQC, must move from being a punitive contributor to the NHS' toxic blame culture to one that learns from unintended clinical error.

In conclusion, professionals are, after all, what health and care is all about. No-one wants a manager, whatever their career or which business school attended, to operate on their brain. But in order to make the health and care service both clinically excellent and efficient in terms of treating more patients and spending taxpayers money wisely, clinicians and managers need to become better informed and more respectful of what each brings to the critical task of improving the health and wellbeing of the UK's population.

THE CASE OF THE 'FAILING HOSPITAL', KING'S COLLEGE HOSPITAL

In December 2017, King's College Hospital NHS Foundation Trust hit a brick wall. Having forecast a loss for the year of £40 million at the start of the financial year in April 2017 (against a 'requirement' from Corporate NHS to break even) the forecast was revised to £90 million, and, worse, the actual underlying run rate pointed to a £180 million loss for the year. Operational performance – against targets like the four hour wait and the 18 week non-urgent waiting list target – was similarly poor.

Within a period of three months, the four most senior officers of the hospital were removed. A highly-qualified, senior manager was parachuted in to turn the operation and its finances around. It provides a useful case study of the failures of management at all levels of the NHS. Indeed, it has been written up as a Harvard Business School case study, which is reproduced in Book 12.

PRESSURE ON THE FIVE MAJOR HEALTH AND CARE DOMAINS

Correcting the constraints to productive reform of the UK's Health and Care Systems will provide a supportive context for managers and clinicians to actively shape services around the needs of patients.[15] Even so, improvements in service will not be just a 'matter of course'. Considerable management skill, resolutely supported by the national bodies, is required. The task is urgent – the NHS and social care are in a deepening crisis.

'Crisis' is a strong and often over-used term. Even before the lockdown and pandemic, public satisfaction with the NHS, as of 2019, was relatively high at 53 per cent. This was driven by their gratitude both to the NHS staff who care for them, and for the service being free. However, these levels of satisfaction are falling, there was a three percentage point drop between 2017 and 2018.[16] This is particularly true for GP services which dropped from a satisfaction level of 65 per cent to just 30 per cent in one year, their lowest level in 35 years.[17]

Even before the pandemic, declining satisfaction was due to deepening fractures in the foundations of the NHS. An April 2019 report by the House of Commons Committee of Public Accounts said:

> *'The NHS's financial health is getting worse: increasing loans to support trusts in difficulty, raids on capital budgets to cover revenue shortfalls, and the growth in waiting lists and slippage in waiting times do not indicate a sustainable position'.*[18]

The pressure on staff throughout the NHS is reaching breaking point, as described by the King's Fund:

> *'It is astonishing that politicians have watched the NHS staff crisis develop to this point without taking action. The reality is more than 100,000 NHS staff vacancies – that's 1 in 11 of all NHS posts. There are very high levels of staff turnover with large numbers of nursing, midwifery and medical staff leaving every month (in secondary care, community services and general practice in particular). And there are chronically high levels of sickness absence and presenteeism. Add to this the struggle most NHS organisations now have in recruiting staff and the picture becomes clear. This is a crisis that threatens the ability of the service to deliver safe, high-quality care for the people in our communities. In any other industry, increasing staff turnover, absenteeism and difficulty recruiting would be seen as red flags, warning of fundamental toxicity in organisational cultures.*
>
> *The latest NHS staff survey data (February 2019) reinforces this understanding. For years, we have recorded high levels of stress that damage staff health, causing a range of issues including cardiovascular disease, diabetes, addictions, cancers, sleep disorders and depression. Fifty per cent more NHS staff now report debilitating levels of work stress compared to the general working population, and year after year, around 40 per cent report being unwell as a result of work stress during the previous year. This affects the delivery of care – undermining safety and quality of care and, in the acute sector, associated with higher levels of patient mortality – and contributes to higher levels of bullying, harassment and discrimination.*
>
> *After 15 years of surveying NHS staff in England, we still see very high levels of bullying and discrimination and little evidence of improvements in staff experience over recent years…The experience of many staff is a toxic cocktail of unmanageable demand and little control.'*[19]

The word 'crisis', however, is unarguable with regard to social care:

> *'Adass*[20] *said social care in England was adrift in a 'sea of inertia' caused by years of budget cuts and [Whitehall] policy paralysis. The system is not only failing financially, it is failing people.'*[21]

This has been exacerbated by the Covid crisis with record levels of medical staff expressing a desire to leave the service as reported by the Doctor's Association, 2021.[22]

The pressure on the system is apparent in all of the five major health and care domains:

- **Mental health** has been a perennially under-resourced and under-managed domain. The decision to close the old 'mental asylums' was, of course, correct, but community provision has not developed in line with community need;

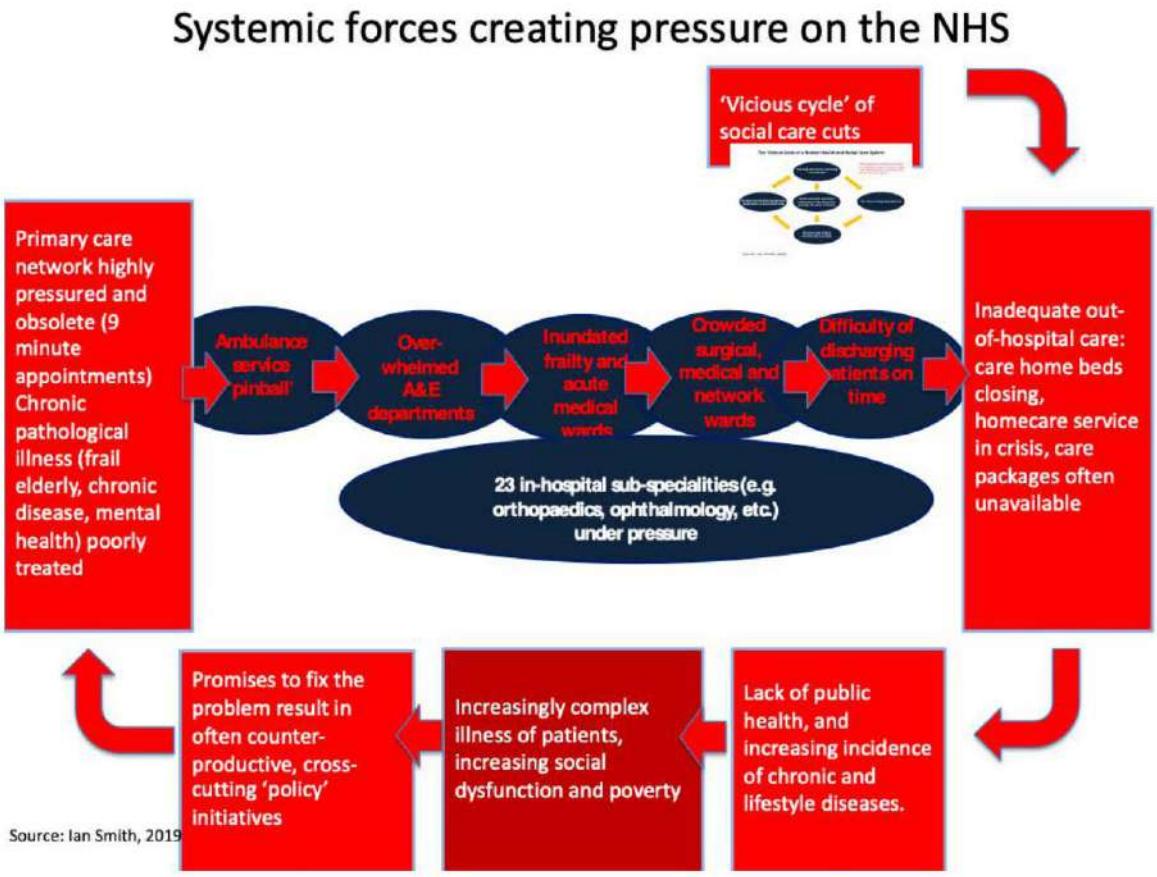
- **Community-based care** helps people who need care and support to live as independently as possible in the community and to avoid social isolation. The services are aimed at the elderly and those who have mental illness, learning disability and physical disability. 'Need' is determined by a health assessment conducted by the local authority. Acute medical conditions are treated free of charge by the NHS, but many chronic conditions, such as frailty and dementia and many mental health conditions, are not treated for free and have to be paid for privately or endured. If a person's capital (including their house) goes below £23,250, measured by the means test, then the local authority will contribute to either placement in a care home, or domiciliary care (home help), though the threshold for getting some council support to pay for costs is soon to be made more generous, with people with assets up to £100,000 able to qualify. These services are provided by private companies and represent the bulk of local authority spending on community-based care. The local authority might provide other services such as home adaptations, such as a stair lift, and social gatherings in day centres. In total, community-based care is congruent with what is generally described as social care.

- **Primary care** services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care mostly comprises general practice (GPs), but also includes community pharmacy, dental, and optometry (eye health) services.

- **A&E and the Emergency Pathway** refers to patients attending the Emergency Department in an acute hospital or a specialised urgent care centre, and then sometimes being admitted to hospital, thus entering the Emergency Pathway.

- **In-hospital specialities** are the clinical groups mostly within hospitals such as trauma and orthopaedics, ophthalmology, kidney services, etc.

The pressures in these five domains are illustrated in the chart below, introduced in Book 1:



PRESSURE ON THE FIVE HEALTH AND CARE DOMAINS

Relieving the pressure in these five domains is an urgent priority, and each of them requires either greater investment or more coherent and competent management – or both. The relevant reforms for each of them will be described in the next three books in the Radix series. The first of these domains, mental health, will be considered here.

The challenge of mental health (the first domain).

SECTION 2

Even measuring the extent of mental illness today is difficult, and it is particularly difficult to measure it over time, given changing definitions and attitudes. **But** there is evidence that some pressures of modern life are contributing to increased mental illness, especially amongst the young.

> *"NHS Digital has released new data which looked at the prevalence of mental health problems among children and young people between the ages of 2-19.*
>
> - *One in eight (12.8 per cent) of children and young people aged between five and 19 has a diagnosable mental health condition. In 2021 it found that one in six children in England had a probable mental disorder.* [24]
>
> - *The prevalence of 5-15 year olds experiencing emotional disorders (including anxiety and depression) has increased by 48 per cent – from 3.9 per cent in 2004 to 5.8 per cent in 2017.*
>
> - *Nearly a quarter (22.4 per cent) of young women aged 17-19 has an emotional disorder*
>
> *A third (34.9 per cent) of the young people aged 14 to 19-years-old who identified as lesbian, gay, bisexual or with another sexual identity had a mental health condition, as opposed to 13.2 per cent of those who identified as heterosexual. Only a quarter (25.2 per cent) of 5-19 year olds with a mental health condition had contact with mental health specialists in the past year, meaning that three-quarters hadn't had any contact with mental health services.'* [25]

There is also evidence that the most acute, and less arguable, categories of mental illness are on the rise.

> *'Severe mental illness affects around 0.9 per cent of the population and numbers appear to be growing. Over 550,000 people registered with a GP had a diagnosis of schizophrenia, bipolar affective disorder or other psychoses in 2017/18, an increase of over 50,000 since 2014/15.'*[26]

One thing that is being more clearly understood is the human cost of mental illness not only in terms of mental wellbeing, but also in terms of the physical harm and, conversely, the impact of physical illness on mental illness. A BMA report on mental health says:

> *'Third world mortality in a first world country. This is how one expert in the field of psychiatry describes the disparity in mortality rates experienced by people with mental health problems in high-income countries like the UK.[27] One in three of the 100,000 people who die prematurely each year in England have a mental illness: on average, men with mental health problems die 20 years earlier, and women die 15 years earlier, than the general population. While this shortened life expectancy reflects higher rates of suicide, as well as accidental and violent fatalities, the majority of deaths in this group arise from preventable causes and could have been avoided by timely medical intervention.*
>
> *It is now well-established that people with mental health problems are at an increased risk of adverse physical health outcomes. Among patients with a severe mental illness (SMI), such as schizophrenia, an estimated 60 per cent of excess mortality is due to physical illness: a person with an SMI is more likely to have a co-morbid physical health problem, and is more likely to die of that illness within five years, when compared to the general population….*
>
> *….More recent findings from the 'Confidential Inquiry into premature deaths of people with learning disabilities' (CIPOLD) – which investigated the deaths of 247 people with an intellectual disability across five primary care trust (PCT) areas in the south west of England – showed that 29 per cent experienced difficulty or delay in diagnosis, further investigation or specialist referral for an illness.*
>
> *In the worst cases, people with intellectual disabilities continue to suffer unnecessarily with untreated, or poorly managed, conditions. The persistent excess morbidity and mortality in people with mental health problems, and in people with an intellectual disability, underlines the urgent need to redress the situation and make 'parity of outcomes' across physical health, mental health, and intellectual disability a reality.'* [28]

Poor provision of mental health services falls disproportionately on the most disadvantaged in our society, especially BAME communities:

> *'Even as the UK becomes more mindful of mental health issues such as depression and anxiety, large disparities still exist in the access to support and treatment for black and minority ethnic (BAME) and white communities. In fact, the latest NHS figures show a white person with mental health issues is twice as likely to receive treatment than someone from an Asian or black background. An independent review of the Mental Health Act submitted to the government in 2018 also discovered "profound inequalities" in how BAME patients are able to access mental health services. The review drew attention to the over-representation of BAME inpatients in psychiatric units: black Britons are four times more likely to be sectioned than white patients, BAME patients are also more often given medication instead of being offered more expensive options such as counselling or psychotherapy. The review called for sweeping reforms to end the "burning injustice" that sees people from ethnic minorities disproportionately sectioned.'*[29]

And again:

> *'Poor mental health underlies risk behaviours, including smoking, alcohol and drug misuse, higher-risk sexual behaviour, lack of exercise, unhealthy eating and obesity. Risk factors and behaviours cluster in particular groups. For instance, low income and economic deprivation is particularly associated with the 20–25 per cent of people in the UK who are obese or continue to smoke.*[30] *This population also experiences the highest prevalence of anxiety and depression.*[31] *Clustering of health-risk behaviours in childhood is a particular problem that leads to greater lifetime risks of mental illness, as well as social, behavioural, financial, and general health problems.'* [32]

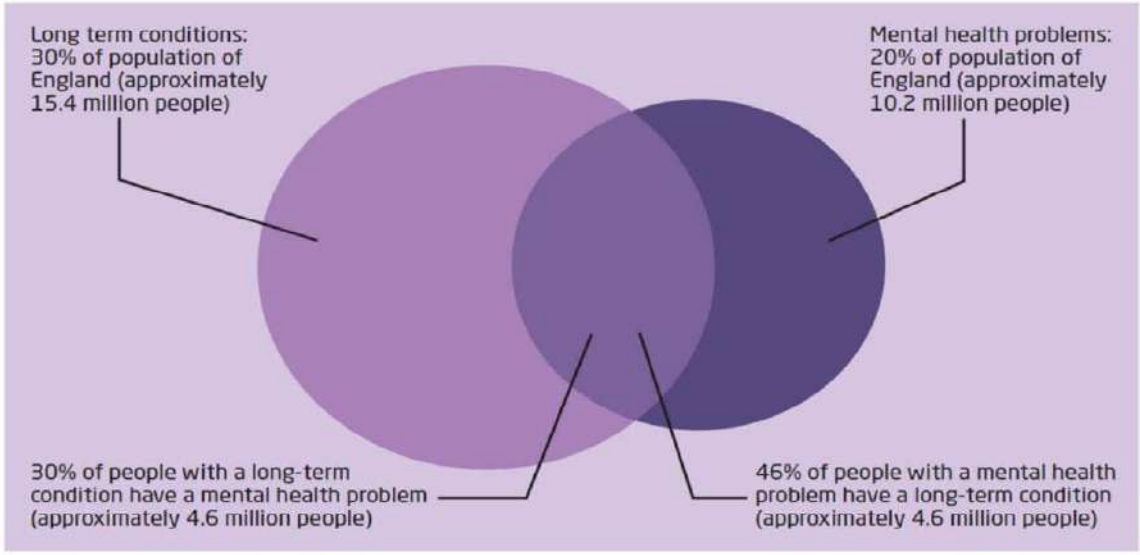
To this last point, most mental health problems appear in childhood and adolescence, giving some children reduced chances of leading a fulfilling life. Poor mental health in childhood and adolescence is associated with a broad range of poor health outcomes in adulthood, including higher rates of adult mental illness, as well as lower levels of employment, low earnings, marital problems and criminal activity.[33] In particular, conduct disorder is associated with increased risk of subsequent mental illness, including mania, schizophrenia, obsessive–compulsive disorder, [34] depression and anxiety, [35,36] suicidal behaviour, [37,38] and substance misuse. [39] Conduct disorder is associated with increased risk of personality disorder, with 40–70 per cent of children with conduct disorder developing antisocial personality disorder as adults.[40]

The congruence of chronic physical disease and mental health is illustrated in the graphic below.[41]

Mental illness is clearly a problem that needs serious attention.

MENTAL HEALTH PROVISION IN THE UK IS POOR, DESPITE GOOD INTENTIONS

The overlap between long-term conditions and mental health problems



It is encouraging that the link between physical and mental health is becoming increasingly recognised. And it is encouraging that research shows that interventions, especially in childhood, can have an important impact on a child's life chances.

Mental health is clearly then a major issue that needs to be addressed, and the good news is that, with the right interventions, mental health can be improved, especially if treated early in childhood.

> *'Since the majority of lifetime mental illnesses develop before adulthood, prevention targeted at younger people can generate greater personal, social and economic benefits than intervention at any other time in the life course...*[42] *Systematic reviews of pre-school and early education programmes show their effectiveness in enhancing cognitive and social skills, school readiness, improved academic achievement and positive effect on family outcomes including for siblings,*[43,44] *as well as prevention of emotional and conduct disorder (Box 4).*[45] *Home visiting programmes improve child functioning and reduce behavioural problems.'* [46,47]

Like social care, mental health has been the 'poor relation' of the country's health and care system. The reasons for this may be rooted in history.

The medical profession for 100 years or so was focused on curing pain and physical disability and that is where its standing and reputation was grounded. Psychiatry, and even more so psychology, seemed to the public, and often to the medical profession also, to have required less precise skills. Another factor may be the stigma historically associated with mental health issues, which still exists today, although thankfully to a much lesser extent. This may have caused it to be pushed to the sidelines in the past. As many as 150,000[48] people were incarcerated in institutions – effectively prisons – even as late as the 1950s in the UK. Despite the UK government's and senior NHS managers statements about 'parity of esteem' for mental health compared to physical health, there is very little increased commitment of time or money on the ground. Mental ailments still receive very little treatment in the United Kingdom. Over 80 per cent of those suffering severe conditions, and 94 per cent of those with moderate ones are treated by non-specialists, or not at all. This compares to an OECD average (still too low) of just over 75 per cent and 90 per cent respectively, with the best performers, as so often, being the Scandinavians and the Dutch.[49] Lack of training means GPs and other primary care practitioners miss many cases.

Politicians have launched new slogans, such as 'Parity of Esteem' for mental health (with physical health), and new services.

> *'Mental health treatment will be offered to 30,000 people with long-term physical problems in a new NHS initiative unveiled today. Therapists will be available to patients with conditions including heart disease and diabetes from next month as part of a two-year programme. NHS England will provide £31 million to fund the integrated services, which will start in 30 areas. Local health managers will be able to apply for an additional £20 million in funding.*
>
> *The cash will fund trainee therapists and experienced clinicians, many of whom will be based in GP surgeries, and will finance more training for therapists running support groups for people with long-term illnesses.'*[50]

But this programme, launched in 2016, has failed to materialise. Even the Sure Start programme, despite its well-researched cost-benefit analysis has been cut:

> *'Conservative cuts to councils have resulted in the funding for Sure Start – once a flagship scheme to support children in the early years – being halved over eight years, it has been revealed. Figures in a National Audit Office report show a £763m slump since the coalition government was first elected in 2010, while funding for services for young people has fallen by £855m.'*[51]

REFORMING MENTAL HEALTH PROVISION IN THE UK

This section will discuss the reforms required to improve the UK's care for those with mental health conditions. They are:

- Take sustained action within the Integrated Care Systems, with appropriate funding to match the good intentions.
- Manage joined up care pathways over full cycles of care for those with a mental health condition (as part of a High-Risk-Care-Management programme).
- Pay particular attention to children and adolescent mental health services (CAMHS) to stop vulnerable people 'bouncing' in and out of mental hospitals, and an end to the harsh cliff-edge as CAMHS services are withdrawn when a person turns 18.
- Deliver on the pledge for more resources in community care, and extend the scope of attention into problem families and the criminal justice system.
- Invest in the workforce and encourage respect.

A MANDATE TO INTEGRATED CARE SYSTEMS

The ICSs are an opportunity to finally put mental health on an equal footing with physical illness – and to recognise that they are intimately linked. Spending on mental health, the evidence shows, will reduce spending on physical illness, and ICSs are the channel for making these integrated spending decisions. Better integrated management of physical and mental health is cost efficient. More importantly, it can have a significant and positive impact on the individual's quality of life. Australia has been particularly determined to deliver an out-of-hospital, integrated service:

> *'Most treatment, even for severe conditions, is at home, with backup from crisis-resolution teams that combine social and medical care. The country's family doctors are being trained to identify and treat mental problems, and paid to hire mental-health nurses. An early intervention model for psychosis, which aims to diagnose patients and provide intensive care quickly after the onset of symptoms, has been shown to improve patient outcomes and is now being copied elsewhere.'*[52]

The Royal College of Psychiatrists speaks for all in health and social care in hoping that ICSs will act to integrate mental health services fully into the health and care system.

'As all areas work towards becoming ICSs this is likely to significantly change the delivery of care in all local areas in England. And so there's a huge opportunity for mental health services to be integrated more comprehensively into the wider health system and to give better, more joined up care to people with mental illness….

…As ICSs develop, health services will be systematically reviewed and re-configured. This throws up challenges around the viability of mental health trusts, many of which might be too small to have their voice heard and could face re-organisation.'[53]

This last point is also an encouraging one: that the rise of ICSs will also mean the breaking down of many of the institutional barriers to joined up care for those with mental health conditions. Clearly this needs to be done carefully so as to make sure that, instead of fully integrated mental health services, we don't end up with the opposite – the disbanding of current services as resources are diverted to physical medical services, as has happened in the past.

JOINED UP CARE PATHWAYS

The Royal College of Psychiatrists have polled their members, and there is a strong wish for more joined up care pathways:

'More seamless pathways of care, with better integration between services to ensure people do not fall through gaps and a single point of access to care. This could include transfer from primary to secondary care, or to third sector support services, or following discharge from inpatient care to community or primary care, leading to another suggested marker of fewer delayed discharges from inpatient care. Some specific care pathways were highlighted as requiring improvement, including secure care and crisis care pathways, which it was suggested needed to be more integrated with emergency departments and outreach from local inpatient units. It was suggested that the medical model of continuity of care must be applied to the mental health service. Other improvements to care pathways suggested as markers of success was needs-based rather than a diagnosis-based assessment; or, put another way, person-centred rather than disease-led pathways. One way this could be achieved is through a system where services gather around the patient, especially for complex care, rather than the patient undergoing serial referrals.'[54]

The integrated care proposition puts the unique personal pathology of the individual at the core of the system. The task is not to farm out each problem to a distant 'expert', but to look at the individual expression of pathologies and treat these in a personalised and systemic way. Experts are, of course, the 'king-makers' in that they will, in many cases, make the key interventions that will transform or even save lives, but they need to be supported by a context that will allow them to do their 'magic'.

A single clinician needs to be in charge of integrating the care pathway of a person with mental health issues. Currently pathways are disjointed and even chaotic. In Book 7 on primary care, the implementation of High-Risk-Care-Management is discussed, and a key beneficiary of that approach will be those with mental health conditions. Mental health needs to be a key part of the type of High-Risk-Care-Management programme that is described later in this series.

CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

It is particularly important that the personalised care of the ICS concentrates on early onset mental health, as is done in Australia:

> *'The biggest gains will come from improving mental-health services for young people. Half of adults with long-term mental conditions suffered their first symptoms before turning 14. Left untreated, even moderate conditions such as anxiety, hurts school results and the prospects for employment. For serious conditions such as psychosis, prompt treatment greatly improves outcomes…. Australia's 'Headspace' centres, which combine a range of health and employment services for 12- to 25-year olds, make it easier for the embarrassed or ashamed to seek help. Finland, Norway and Sweden have schemes in schools to tackle the stigma of mental illness.'*[55]

The disjointed nature of care pathways currently is particularly disturbing for children and adolescents. My brother Ian used to chair the Huntercombe Group, which provided secure mental health service, and was one of the largest providers of CAMHS tier 4 services that caters for children and adolescents with extreme mental health problems.[56]

"There were many instances of children being in our care but who were placed back in the community prematurely, usually because the commissioner had run out of money, where there was no continuity of care. The same child would arrive back in our facility, often via a couple of nights in a police cell, just a few weeks later" he said.

Over the last few years, the government has launched a number of reviews of CAMHS services, and it has been frustrating that the pleas of our psychiatrists and psychologists for continuity of care has been ignored, the focus usually being on how to save money and reduce the number of beds. Hopefully, the rise of ICSs will make this pattern a thing of the past.

This issue of continuity of care is also important in the transition from children's to adult's services. The impassioned plea expressed by a clinician in this piece is shared by all in the sector:

> *'Young people face a 'cliff edge' when trying to access mental health care after reaching the upper age limit of child and adolescent mental health services (CAMHS), usually at the age of 18. If they still require support, care should be transferred to an adult mental health services (AMHS), through a process known as transition. Distinct from a simple transfer of care, transition should be part of the therapeutic process, taking into account the young person's preferences, current circumstances and developmental maturity (NICE, 2017).*[57] *However, we know that in most cases transition doesn't occur, leaving young people to try to manage their illness on their own. In a systematic review I conducted which was published earlier this year, only 25 per cent of young people were transitioned to AMHS, with another 25 per cent remaining in CAMHS even after crossing the age boundary. There were no records for what happened to the remaining 50 per cent , meaning we do not know what happened to them after leaving CAMHS.'* [58]

EXTENDING THE ICS INTO THE REALM OF THE 'TROUBLED' FAMILIES, THE CRIMINAL JUSTICE SYSTEM, AND MORE BROADLY INTO THE DEVOLVED LOCAL GOVERNMENT SYSTEM

Broader social care should be integrated alongside physical and mental healthcare in a properly joined up system including programmes on social or community engagement, employment, housing and education.

Australia is a leader in taking mental health seriously, really giving it 'parity of esteem', and placing mental health in the broader social and economic context, as the following description shows.

> *'Australia leads the way in innovative approaches and has a large number of community services, including crisis and home treatment, early intervention and assertive outreach.*

A recent OECD report **Making Mental Health Count** *noted that the proportion of spending on public psychiatric hospitals dropped from 46 per cent to 12 per cent of the total mental health budget while expenditure on community psychiatry rose from 24 per cent to 39 per cent.[59] Though other countries spend more on mental health in absolute terms, Australia has managed to transform its model of care most successfully to date because successive governments since the early 1990s have made significant policy and funding commitments, including investments in technology. These plans were first started in 1992 with the National Mental Health Strategy and have been repeated every five years or so since.*

Australia is ranked first on the 2014 OECD Better Life Index, which measures a number of social determinants that support good mental health: employment, civic participation, education, sense of community, work-life balance and other factors which promote well-being and health.' [60,61]

TROUBLED FAMILIES

It is estimated that there are 120,000 core 'troubled' families in the United Kingdom.[62] The government classes a family as troubled if it meets five of six criteria. These are low income, no one in work, parents with no qualifications, parents with mental health problems, parents with longstanding illness or disability, and if the family cannot afford basic food and clothes.[63]

These families draw substantially on the health and social care systems. Their lifestyles include use of alcohol, smoking, poor diet and possibly drug abuse; they may take up a lot of police time and offender management. A further 380,000 families have been identified representing the next tranche sharing similar characteristics of disadvantage and dysfunction.

There are encouraging signs that the issue is being addressed. The Troubled Families programme was launched by the UK Prime Minister, David Cameron, in 2011. Following a government announcement in January 2020, the second phase now running to March 2021, with annual progress reporting until this year.

The cost to society of coping with the problems related to troubled families vastly exceeds spending for non-troubled families, as these figures reveal.

- In West Cheshire, the council spends on average £7,795 per family per year in its area, compared to £76,190 for a troubled family. In Solihull, local services spend an average of £5,217 per family, compared with £46,217 on a troubled family. In Barnet, greater London, the amount spent on a troubled family is estimated at nearly £100,000. [64]
- The government in December 2011 estimated the cost of a troubled family to be an average of £75,000 per year, based on the overall costs analysis produced for the initial stages of securing funding for the national Troubled Families Programme. [65]
- The Home Office estimates that the total cost of crime committed by troubled families could be as high as £2.5 billion if health service crime costs are included. [66]
- Child protection is a major cost. Separate figures estimate that more than £3.4 billion is being spent on protecting children from troubled families, including large amounts to pay for them to be adopted, fostered or placed in residential care.[67]
- According to the same source, 'the most significant spend lines relate to residential care, fostering and adoption service.' More than £1 billion is spent annually on fostering, almost £800 million on residential care and £200 million on adoption services for the children of the families.[68]

These troubled families need to be a part of the integrated care system that we are advocating. Indeed, this cohort of needy people and frail older people are the two most 'high risk-high cost' groups in our society.

CRIMINAL JUSTICE SYSTEM

The knock-on effect of failing to deal with 'troubled families' and mental health adequately can be a rapid rise in the prison population. The statistics below reveal how fast the prison population is expanding.

> *'The prison population in England and Wales, including those held in Immigration Removal Centres, was at a record high of 88,179 prisoners on 2 December 2011. The Scottish prison population reached a record high of 8,420 on 8 March 2012 ...*
>
> *....The prison population in post-war England and Wales has risen steadily. Following a marginal reduction in the early 1990s the increase has become more marked: the prison population has increased on average by 3.7 per cent in each year since 1993.'*[69]

The police force is increasingly used as the front line in treating individuals with acute mental health needs:

> *'British police spend as much as two-fifths of their time dealing with cases that involve mental illness, though few have the necessary training. Across Europe, 40-70 per cent of prison inmates are mentally ill....In Britain, mental-health nurses join police officers on patrol. Their contribution can be as simple as using health records to find the address of someone who is acting oddly or causing a disturbance, or to assess the threat he poses. In a pilot scheme, the approach led to police detaining 26 per cent fewer mentally ill people and sending more who needed acute care to psychiatric assessment rather than a jail cell.'*[70]

THE LOCAL STATE

There is a correlation between the UK's wealth and income inequalities and disadvantaged health and social care outcomes for the poorest people in our society, of which mental health is a key factor. There is broad political consensus that this problem of poor outcomes should be addressed in its own right, as well as for the good reason that it is very expensive for the UK taxpayer.

Australia, again, provides some useful pointers to effective action.

> *'One of the most notable features of Australia's healthcare system is its progressive approach to mental health. In moving away from the old model of 'warehousing' psychiatric patients in hospitals, it has developed a proactive community system with many services, such as crisis and home treatment, early intervention and assertive outreach based on a life-course approach.'*[71]

Devolving responsibility for health and social care to local health and care economies, and to ICSs, will allow for more targeted and customised attention to mental health.

INVESTING IN THE WORKFORCE

Despite good intentions, investment in the mental health workforce has not been good. A 2020 BMA report says that:

- *'Many of the mental health workforce commitments in stepping forward to 2020/21 and the five year forward view for mental health are not on track to be met.*

- *The mental health workforce has had little growth over the past 10 years, many of the key staff groups either remaining at a similar level since 2009 or declining.*

- *Demand within mental health services is rising - since 2016 there has been a 21 per cent increase in the number of people who are in contact with mental health services (1.4 million in 2019 versus 1.1 million in 2016).*

- *Recruitment into psychiatric specialties remains a key challenge with many psychiatric specialties facing under-recruitment year on year.*

- *Workforce shortages in mental health are affecting staff workload, well-being, morale and the ability for staff to provide good quality of care.'*[72]

Clearly, this situation needs to be turned around, especially given the impact that the Covid-19 pandemic has been having on mental health.

Managing a provider of mental health services is challenging. Obviously, people with acute mental health problems are highly challenging individuals to care for. Yet politicians and the media are often too eager to highlight often spurious instances of abuse. Of course, we must always be alert to abuse. This is especially true for the two groups of people who run the risk of being coerced and silenced: children and those with learning disabilities. Both providers and the CQC have a solemn duty to be particularly vigilant in these environments.

At the same time, we need to be supportive of highly skilled individuals who do a very difficult job with very troubled people. Rather than quote some dry facts and statistics, this section is concluded by a description of a day spent as a carer in an acute mental health facility by a senior manager, my brother Ian.

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