ARTICLE

Why care about integrated care? Part I. Demographics, finances and workforce: immovable objects facing mental health services*

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SUMMARY

Demands on health and social care are growing in quantity and complexity, with resources and staffing not projected to match this. The landmark NHS Long Term Plan calls for services in England to be delivered differently through integrated care systems (ICSs) that will better join commissioners and providers, and health and social care. The scale of these changes is immense, and the detail can feel confusing. However, they are important and will affect all clinicians in the public service. This three-part series provides a primer on integrated care, explaining why it is happening, how services are changing and why clinicians should get involved. In this first article we focus on the changing demographics, and the workforce and financial resources required to address these.

LEARNING OBJECTIVES

After reading this article you will be able to:

- appreciate the changing demographic, clinical and social factors that influence service need
- detail the challenges of staff recruitment and retention, and current and planned funding in England
- understand the complementary and unique challenges faced by social care, and how these might impact closer alignment with healthcare.

DECLARATION OF INTEREST

None.

Keywords

Integrated care; integration; NHS Long Term Plan.

Health and social care are struggling to meet increasing needs, and the highly significant policy and service changes proposed by NHS England to meet these challenges will soon affect every clinical team. Demand is growing (and growing more complex), and there is a workforce recruitment and retention crisis (Tracy 2019).

Healthcare is a regionalised function in the UK, with funding determined centrally, but spending decisions made by the devolved administrations. The funding landscape is complex, with figures on health and social care spending including out-of-pocket and insurance funding as well as local authority (and not central government) spending. The Office for National Statistics shows that the 2017 UK healthcare expenditure accounted for 9.6% of gross domestic product (GDP), and the Organisation for Economic Co-operation and Development (OECD) estimates the UK's combined health and social care costs at £208 billion a year (Appleby 2019), or 21% of all government spending (Charlesworth 2018). This enormous figure is still not meeting need.

The Health and Social Care Act 2012 had a profound impact on services in England, embedding a quasi-marketplace of choice and competition, including payment by results (PbR), purportedly to improve efficiency. It established NHS England as a statutory and independent body aimed at removing political micromanagement and replaced primary care trusts (PCTs) with clinical commissioning groups (CCGs). However, it has been argued that these so-called 'Lansley reforms' (named after the then Secretary of State for Health Andrew Lansley) have exacerbated the current problem of fragmentation of services and hindered effective patient care. Change is required in both the financing and organisation of healthcare, including better alignment with social care.

The 2019 NHS Long Term Plan (NHS England 2019) and – if it arrives – social care green paper, are proposed to redress this demand–supply mismatch in England, primarily through better utilisation and refocusing of existing resources, although

*This is the first of three articles in this issue focusing on integrated care.

more money has also been promised (at least to health). The key principle is of more 'integrated care' and a move to integrated care systems (ICSs). ICSs – which will be more fully covered in our second article – are intended to bring together commissioners and providers in a non-competitive manner to assess local population well-being and need. They are expected to deliver better, more seamless, care to local populations, focusing on preventive work and minimising unnecessary acute care.

Despite these laudable aims the details on ICSs remain vague, particularly with regard to mental health services, and the scope and scale of the proposed changes have often confused clinicians (Tracy 2019). This three-part series (described in Box 1) provides a primer on integrated care with a focus on its impact on psychiatry. It outlines the current and projected demographic and clinical landscape, the legislative and policy changes designed to try meet these, and gives an overview of different, early integrated services and the practical issues they have faced.

Integrated care, in one form or another, will be coming to all services in England whether wished for or not. These three articles focus on recent legislative changes in England, but the challenges and approaches are similar across the other home nations. Scotland (Scottish Government 2016) and Wales (Welsh Government 2018) have integrated care plans with similar goals, and Northern Ireland has had integrated health and social care for many decades. We argue that there will not be the option to ignore these issues or changes. However, there is an opportunity to help sculpt and optimise these locally, to provide better, more joined-up care for patients, improving outcomes.

BOX 1 The three-part series on integrated care and its impact on psychiatry

Part 1 describes the challenges of growing service demand, and problems in the supply of health and social care funding and staffing.

Part 2 describes the evolution of mental health services in the UK, locating the current reforms against the background of previous ones. It details policy and legislative aspects, including the Health and Social Care Act and NHS Long Term Plan. The more granular structures that are evolving from this – such as sustainability and transformation partnerships (STPs), integrated care systems (ICSs), integrated care partnerships (ICPs) and primary care networks (PCNs) – are explained.

Part 3 describes practical aspects of integrating services, drawing on the experience of different NHS organisations and their social care partners. It tackles 'which' services might be integrated and the challenges of aligning health and social care with clinical commissioners. This includes the notable impact of changes on front-line staff. Wider working with local communities, including 'social prescribing', and potential technological assists are discussed.

The challenge of demand: demographic, clinical and social profiles

A growing, ageing population

The UK population continues to grow, with a predicted additional 4 million people by 2035 and, crucially, a doubling of those over the age of 65 (Kingston 2018). Life expectancy has been rising since first recorded in the mid-19th century. Initial gains were through reduced child mortality and improvements in basic sanitation, hygiene and housing conditions. This continued in the 20th century through the introduction of childhood vaccination programmes and universal healthcare coverage – what Deaton called the 'great escape' (Deaton 2013) – and more recently through modifying lifestyle risk factors of diet, exercise, cigarette smoking and alcohol consumption. Gains have slowed during the second decade of the 21st century, but by 2016–2017 half of new-born females could expect to be alive at 85.8 years of age, half of males at 82.3 (Office for National Statistics 2018). Most recent data suggest that life expectancy has reduced slightly (Institute and Faculty of Actuaries 2019). The reasons for this remain heavily debated, although it has been argued that austerity and cuts to health and social care are key drivers and the UK has some of the lowest investment in public sector infrastructure in the OECD (Marmot 2010; Raleigh 2018).

To capture quality of life as well as longevity, the concepts of 'healthy life expectancy' (HLE) and 'disability-free life expectancy' (DFLE) are increasingly used. HLE is the number of years individuals perceive that they live in 'good' or 'very good' general health; DFLE is an estimate of the number of years lived without a long-lasting physical or mental health condition. Currently, UK HLE at birth is 63.1 years for men, 63.7 for women: as men have lower life expectancy, this is a greater percentage (79.6%) of men in good health than women (76.9%); indeed, the figures have worsened for women over the past 5 or so years.

An increasingly multi-morbid population

The UK population is growing clinically more complex, with more risk factors for ill health, and rising rates of comorbid conditions; this is significantly affecting the populations seen in mental health services. High body mass index (BMI), smoking, excess alcohol consumption, limited

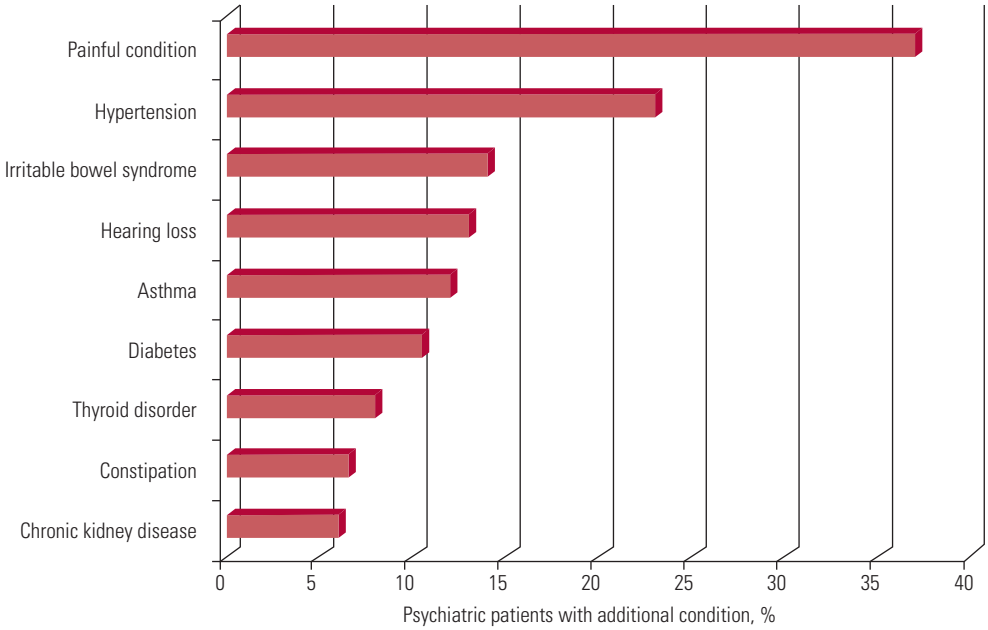

FIG 1 The most common additional conditions for people with a mental illness and the proportion of people affected. Adapted from Stafford *et al* (2018).

exercise and poor diet remain the leading morbidity risk factors (Public Health England 2018a), and all are higher on average in populations with mental illness. Smoking and alcohol consumption have fallen in recent years, but obesity rates have increased. Data from England in 2008 show that only 6% of individuals had none of these risk factors, whereas 5% had at least four and 70% of the population did not adhere to government guidelines on at least two (Buck 2012). Obesity in particular is seen as a key driver for many illnesses and rates are increasing in all age groups (Stevens 2012).

Multi-morbidity is a growing health challenge: the number living with four or more illnesses has been forecast to quadruple in England by 2035 (Kingston 2018). In a report on the healthcare needs of people with multiple conditions the Health Foundation estimated that 30% of those currently living with four or more conditions are under 65 years of age (Stafford 2018), so this challenge of multi-morbidity is not limited to older populations. Figure 1 shows the most common comorbidities of those with a mental health condition. The report also noted that those with two or more conditions accounted for over half of primary and secondary care costs, and three-quarters of primary care prescription costs. Over a 2-year evaluation period, those with more than four conditions had a mean of 8.9 out-patient visits, once-monthly general practitioner (GP) visits and 20.6 prescribed medications.

Those with greatest need are often least able to manage their multiple appointments and medications, leading to fragmented care, exacerbation of their conditions and higher use of emergency care; they also suffer higher rates of social isolation, loss of work and financial hardship. Their numbers, and the demands on services, are increasing, and at present they commonly move across multiple services in an inefficient and costly manner.

Mental health morbidity, prevalence and societal impact

The Adult Psychiatric Morbidity Survey of 2014 (McManus 2016) reported that 17% of surveyed UK adults met the criteria for a common mental disorder. This has been increasing across the four survey periods since 1993, largely driven by an increase in rates in women. Notably, only 39% of those in need were accessing treatment, although this was up from 24% in 2007: already pressured services are seeing only a minority of need.

The Royal College of Psychiatrist's projections are that there will be an increase in demand across all mental health clusters in the coming decade (Royal College of Psychiatrists 2019) (Fig. 2). The utility of these clusters remains heavily debated, but the underpinning message is clear. Demand growth is most notable in cognitive impairment and dementia, with modelling studies estimating that an additional 312 000 people in England will be living with dementia by 2029, at a societal cost of an additional £10 billion a year (Prince 2014). However, the other end of the lifespan is equally critical, particularly for

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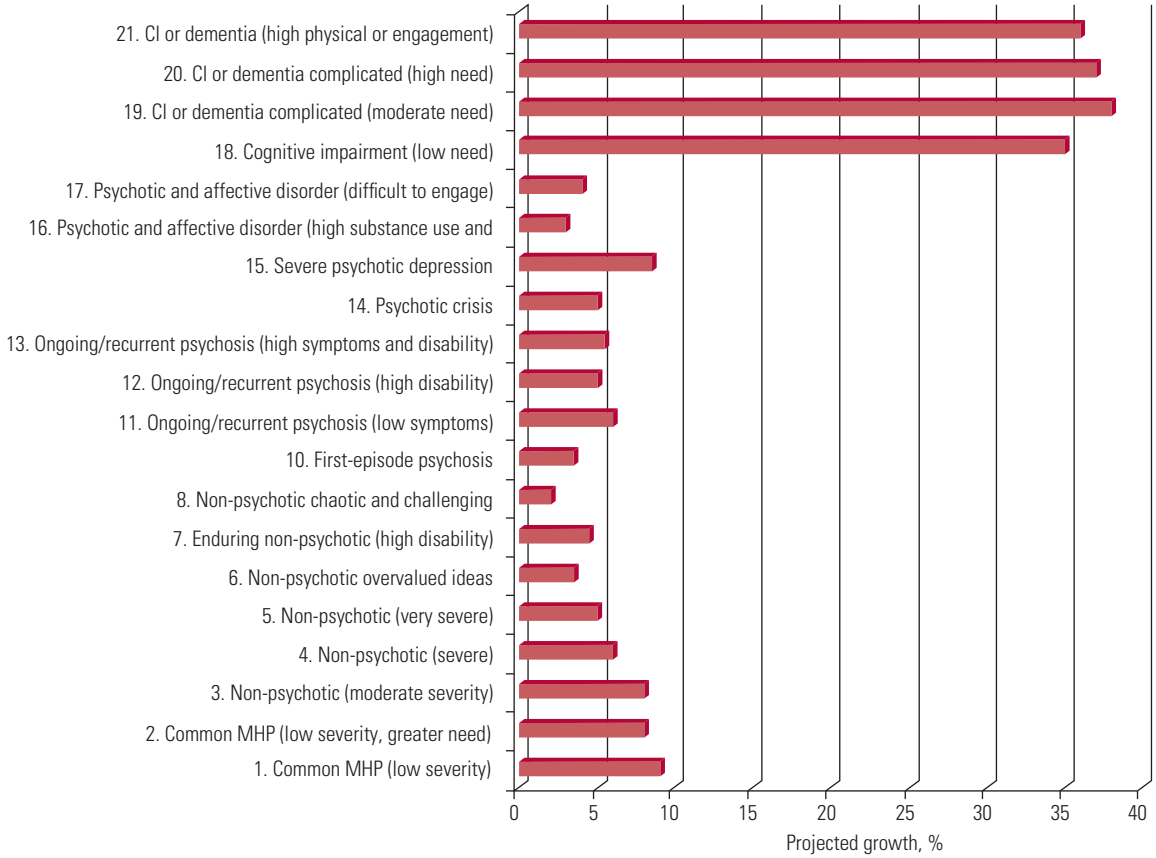

FIG 2 Estimates of projected percentage growth in demand across mental health cluster caseloads in England between 2018 and 2024. There are slight differences in projections between men and women: these data take an average between them. CI, cognitive impairment; MHP, mental health problem. Adapted data from Royal College of Psychiatrists (2019: p. 8).

prevention, with about half of mental health problems estimated to begin by the age of 14 and three-quarters by age 24 (Kessler 2005).

Mental health problems cost the UK about 4.1% of GDP through direct health and social care costs and indirect losses, matching the EU average (Organisation for Economic Co-operation and Development 2018). The Centre for Mental Health noted that in 2016–2017, the UK economy lost £34.9 billion owing to employee mental illness, equivalent to £1300 for every employee in the country (Parsonage 2018). An estimated £10.6 billion was from sickness absence, £21.2 billion from reduced productivity at work (so called presenteeism) and £3.1 billion from replacing staff who left their jobs because of their mental ill health. This was 35% higher than the corresponding figure a decade earlier, although this change is in part due to a larger workforce receiving an (adjusted) higher average salary.

Mortality rates for those who use secondary mental health services have reduced slightly since the turn of the millennium, but on average men using these services die 19 years, and women 16 years, earlier than the rest of the population (Strategy Unit 2017). Many deaths are preventable through better support in lifestyle, preventive approaches, and better medical and medication reviews (Royal College of Psychiatrists 2019). Of note, much of the literature on putative gains from preventive work has focused on physical health factors such as smoking, alcohol and obesity, with far less on potential gains from prevention or early treatment of mental illness (early intervention in psychosis is perhaps the notable exception). Some of this might be due to a lack of clear reliable evidence of 'what works': there is much interest in the impact of 'early years' programmes on outcomes of resilience and well-being, but much debate on their effectiveness and value for money.

Social determinants of health and social outcomes of poor health

A King's Fund report on population health noted six major social areas that affect health and use of public services (Buck 2018): income, housing, the environment, transport, education and work. Note that

healthcare is not among these predominantly socioeconomic and environmental factors.

The landmark 2010 Marmot review of health inequalities in England (Marmot 2010) found that people in the poorest areas were dying an average of 7 years earlier than those in the richest areas, and further, that such individuals spent an average of 17 additional years living with disability. Those in the most deprived areas are twice as likely to die prematurely from cancer, and four times as likely to die prematurely from cardiovascular disease, than those in the least deprived areas; for cardiovascular disease this gap has increased since 2010 (Public Health England 2018a). In 2014–2016 the age-standardised mortality rate for suicide was twice as high in the most deprived decile compared with the least deprived. Low life satisfaction is four times higher among those who are unemployed (Public Health England 2018b). Loneliness is a growing problem: one in eight adults in the UK reports having no friends (Relate 2017), and feeling lonely has been estimated to have the same effect on health as a smoking habit of 15 cigarettes a day (Holt-Lunstad 2015). The number of rough sleepers in England increased by 372% from 2010 to 2018 (Ministry of Housing, Communities & Local Government 2017); there has been an almost 25% increase in deaths of homeless individuals since 2014 – at a mean age of just 44 – and over half of these were from drug poisoning, liver disease or suicide (Office for National Statistics 2019). The Social Metrics Commission (2018) identified that in the UK in 2018:

- 14.2 million (22% of the population) were living in poverty: 8.4 m working-age adults, 4.5 m children, 1.4 m of pension age
- 7.7 million (12.1%) were living in persistent poverty, that is in poverty for most or all the past 4 years
- a 'resilience gap' existed between those in poverty and those who were not.

The costs of social inequities have been estimated at £36–40 billion a year through direct expenditure and lost taxation. York University's Centre for Health Economics has estimated the direct cost to the NHS for failing to provide preventive care to the poorest communities at £4.8 billion a year (Asaria 2016).

Individuals with mental health problems face an increased range of social problems, from poverty and unemployment to greater rates of imprisonment. They are more likely to have difficulties with housing, including rent arrears, live in deprived neighbourhoods and have challenges independently managing daily needs. Over half with psychosis have no stable homes; there is good evidence to support sheltered housing, including as an actual intervention in helping individuals' mental health, but the funding is not always available for this (Centre for Mental Health 2016). Individuals with severe mental illness are more likely to suffer stigma, discrimination and social exclusion, and have more risky health behaviours such as higher rates of smoking – 40% compared with approximately 15% in the general population. They often find it harder to initially access services and, once in services, to receive appropriate preventive help, with the problem of 'diagnostic overshadowing', wherein physical health problems are misattributed to mental illness.

The relationship between mental ill health and social problems is bi-directional. Adverse childhood experiences are linked with a large range of subsequent physical and mental health problems (Herzog 2018; Morris 2019) through direct neurobiological alteration (Morris 2019) and psychological distress from problems such as living alone, unemployment and poor physical health (McManus 2016). Over 50% of Employment Support Allowance claimants have a primary mental health problem (Makurah 2018). Only about 7% of those in contact with secondary mental health services are in paid employment (Public Health England 2018a). In one of the most disadvantaged of all healthcare conditions, people with psychoses form almost 60% of all mental health in-patients and 37–80% of those detained under the Mental Health Act 1983, and account for 80% of all experiences of restrictive practices of restraint, including prone restraint, seclusion and rapid tranquillisation. There are other critical intersectional issues, including gender and ethnicity, for example Black individuals are several times more likely to be detained under sections of the Mental Health Act as well as more likely to be on higher doses of antipsychotics and receive psychological interventions less often than their counterparts from other ethnic groups. The Commission for Equality in Mental Health has been drawing evidence from a wide range of sources on such issues and expects to publish its findings and recommendations in 2020 (Commission for Equality in Mental Health 2019).

The challenge of supply: finances and workforce in health and social care

Funding healthcare

The NHS accounts for about 7% of UK GDP (Stoye 2017), just below the EU-15 weighted average. Over the past decade, funding has increased at about 1% a year in real terms (above inflation), compared with a longer-term historical figure – and that

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recommended by the Office for Budget Responsibility to meet growing need – of about 4%. An important but complex factor within total spending is the efficiency of the money invested. The National Audit Office has estimated that £6 billion in potential savings could be realised by 2020–2021 through reduction in waste and variation in care quality and efficiency (Morse 2018). However, there have traditionally been few national levers to either reduce or measure efficiency improvement.

There has been an increase in the number of NHS trusts now reporting annual budgetary deficits, from fewer than 10% in 2009–2010 to over 40% since 2014–2015. Mental health trusts appear to perform relatively well, with 'only' 19% reporting a deficit in December 2018 (Anandaciva 2018). However, the Royal College of Psychiatrists has noted that the typical block contracts disincentivise increasing activity (unlike the more usual payment-by-results (PbR) contracts in the acute sector), and apparent surpluses may thus mask inadequate funding for true need (Royal College of Psychiatrists 2019). There are also concerns that much of any additional funding is syphoned into the acute sector at the expense of mental health and community services (Charlesworth 2019a). PbR is not without its own problems, and there is a converse argument that the most appropriate way to provide mental health services is to do what one can for a given population within a resource envelope – in other words, a block contract. Parts 2 and 3 of our series address the concept of a capitated budget, where a single provider, or small group of providers, cover all healthcare needs of a defined population in an ICS; this, in principle at least, allows for better oversight of management of complex illnesses and preventive work.

Investment in NHS estates fell by 17% between 2010–2011 and 2017–2018, and there is an increased maintenance backlog. The Department of Health and Social Care's capital budget was 0.27% of GDP, in contrast to the OECD average of 0.51% (Charlesworth 2019a). Again, mental health trusts have suffered relatively greater reductions in capital spends: 39% below that planned for 2017–2018, compared with a shortfall of 29% in acute trusts.

The NHS Long Term Plan contained a commitment to an average increase in NHS England's budget of 3.4% for the 5 financial years commencing 2019–2020 (NHS England 2019: para. 6.1) (Fig. 3). However, the plan does not cover non-NHS aspects such as public health, social care, education or training (Dunhill 2018); indeed, budgets for Public Health England and Health Education England have been cut by 15% and 24% respectively over the past 5 or so years. Further, funding is not evenly divided across the 5 years – the greatest spend will be in 2023–2024 – and is not front-loaded, meaning that services might need to be 'double run' as the new preventive interventions are being established while the excess acute demand is still being met (Charlesworth 2019a).

Funding social care

An ageing population with greater needs will need ever more support from social care. In England, contrasting with treatment – which is provided free by healthcare services – support and personal care required following illness, disability or in old age is either provided by the voluntary sector and unpaid caregivers, or funded privately or publicly. Local authorities have a legal duty of care to provide the publicly funded aspect. There are nationally agreed targets for 'needs testing' (the degree of impairment necessitating input) and 'means testing' (the financial thresholds beyond which individuals contribute to their own care). Most funding is local, coming from business rates and council tax, although central government contributes grants and can influence local authority borrowing and spending priorities. Nevertheless, inequities can arise, with different local authorities spending varying amounts on individuals with similar needs and means, depending on local funding levels and agreed priorities. It is worth noting that housing is not funded through adult social care, with central government spending on social housing falling from 0.7 to 0.4% of GDP between 2004 and 2012, to 0.2% in more recent years, while housing benefit spending on rented properties increased across the same time period from about £16 billion to over £25 billion a year (National Housing Federation 2019).

Nationally, gross expenditure on adult social care has fallen (on a single occasion it remained level) every year since 2009. Local authorities have suffered a 7% decrease in national gross spending during this time, despite a growth in need (Nuffield Trust 2017). Public health services moved to local authorities in 2014 and have suffered a 23% reduction in spend per person between 2014–2015 and 2019–2020. Local authorities are now also responsible for alcohol and substance use services, and with spending no longer ring-fenced, cuts of about 30% have occurred nationally during a similar time frame and the UK has seen a considerable rise in drug-related deaths (Drummond 2017).

In the next 5 years local government income from local taxes is anticipated to grow by 1.4% a year (Charlesworth 2019b), but the Institute for Fiscal Studies (IFS) estimates that an annual increase of 3.9% is required over the next 15 years to meet

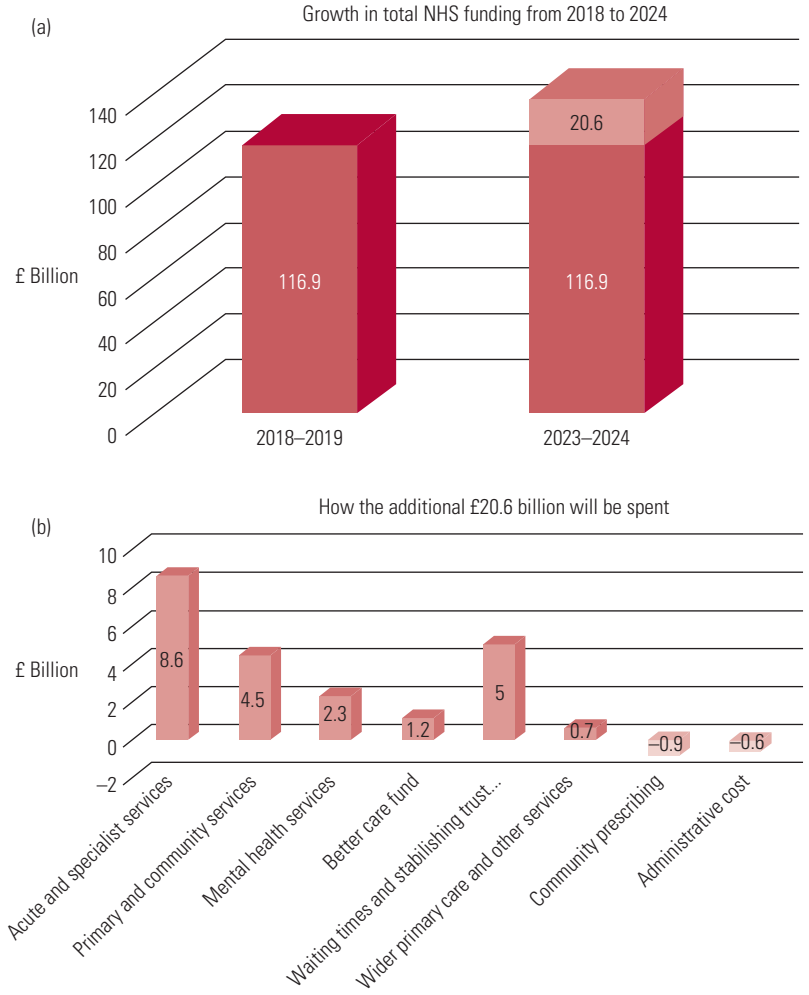

FIG 3 (a) Growth in total NHS funding from 2018 to 2024, from £116.9 billion to 137.5 billion; (b) how the additional £20.6 billion will be spent. Note that there will be reduced funding for community prescribing and administrative costs. Adapted from Charlesworth *et al* (2019a).

need (Charlesworth 2018). A Care and Support Commission's report (often referred to as the 'Dilnot report' after its lead author) supported introducing a cap to prevent people from extreme care costs, and a means test, below which individuals were eligible for local authority support towards care costs (Commission on Funding of Care and Support 2011). Notably, the IFS projection of funding needs is predicated on maintaining the uncapped means test that limits eligibility; clearly, if that were reformed, as has been debated, the cost would be considerably greater. The overarching figure also does not take regional variation into account: poorest areas will be disproportionately hit by austerity and have the highest social care needs, yet are also likely to have the lowest revenue from business rates. Further, if social care salaries were to rise at an equivalent rate to that promised to NHS staff under 'Agenda for Change' (see below), then an additional £1.7 billion a year would be required by 2023–2024 (Charlesworth 2019b).

To redress this funding gap, the 2014 Baker Commission called for a single budget and alignment of health and social care, paid for through taxation and national insurance (Commission on the Future of Health and Social Care in England 2014). A joint report by the House of Commons Health and Social Care Committee and the Housing, Communities and Local Government Committee called for similar charges in what was labelled a 'social care premium' (Health and Social Care Committee 2018). In both cases it was argued that it is important to target wealth as well as income, to avoid solely hitting working-age adults, and that additional responsibilities should be borne by those of state pension age.

The Nuffield Trust recently outlined several options available to better fund social care, including various permutations of increasing general, inheritance and local taxation, voluntary or

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mandatory insurance, and altering caps on lifetime spend or the means-testing threshold (Oung 2019). The various models highlight that there are no easy ways to generate the large funds required, and that each comes with unique costs and benefits. Further, although many people with mental illness clearly have significant social care needs (and *vice versa*), the largest growth in need is from a frail ageing population without mental (or acute physical) healthcare needs, and there are dangers that meeting their enormous and appropriate needs will overwhelm the resources to address those of mental health service patients.

The workforce in health and social care

In March 2018, 1.2 million full-time equivalent individuals were working in NHS hospital and community services, an increase of 1.7% over the previous year; a similar number, 1.1 million, were working in adult social care (Skills for Care 2018). This accounted for about 10% of the entire UK workforce. Across the past two decades there has been a rise of 70% in the number of hospital doctors and 10% in the number of nurses and health visitors (Charlesworth 2018), although compared with other EU nations the ratio of many staff groups per 1000 population is lower than average. Productivity in the NHS has grown at about 1.4% a year since 2009, a figure that is greater than productivity growth in the overall economy during this time (Charlesworth 2018). However, potentially problematically, funding models are predicated on this rate of improvement continuing over the coming 5 years (Ham 2018).

There were 100 000 unfilled posts in the NHS in 2018; in social care the figure was 110 000 (Nuffield Trust 2018). A joint report by the Nuffield Trust, the Health Foundation and the King's Fund projected that this will grow to 250 000 by 2030, and indeed could be as high as 350 000 owing to emerging trends of greater rates of leaving the workforce and fewer international professionals entering (Nuffield Trust 2018). It scarcely needs stating that Brexit could profoundly worsen this. The report argues that there has been inadequate long-term workforce planning, inequity in career progression, and staff burnout in an increasingly pressurised system. There have been central cuts in investment in education and training (from 5% of health spending in 2006–2007 to 3% by 2018–2019). It calls for a sustainable long-term workforce strategy to redress this, including supporting new ways of working for professional groups.

Agenda for Change, the landmark 2004 NHS pay deal for non-medical and dental staff, harmonised pay scales and career progression; these arrangements contrast starkly with those in social care, where pay is often considerably lower than NHS equivalents, and an estimated two-thirds of staff are currently on minimum wage – many of them also on zero-hours contracts (Charlesworth 2019a). The National Audit Office noted that there has not been a national workforce strategy for social care since 2009 and that there is a widespread staff perception of feeling undervalued, underpaid and with fewer opportunities compared with colleagues in healthcare (National Audit Office 2018).

Historically, psychiatry as a profession has always had unique challenges of recruitment into training, with stigma towards both patients with mental illness, and psychiatry and psychiatrists (Patel 2018) – including from other doctors and healthcare professionals. Over the past decade or so there has been an overall growth in full-time equivalent psychiatrists of about 2.5%, although the increase has largely been in general adult psychiatry, with decreases in the numbers in psychotherapy, intellectual disability ('learning disability' in UK health services) and old age psychiatry. The 4.7% increase in consultant numbers between 2012 and 2019 should be contextualised by an average growth of 28.7% in other medical specialties over the same period (NHS Digital 2019).

Recruitment into training has pleasingly improved over the past couple of years (Health Education England North West 2018), and the Royal College of Psychiatrists has been active with its 'Choose Psychiatry' campaign and engagement with medical schools (Pandian 2020; Mulliez 2019). However, this will take time to translate into consultant psychiatrists, where the vacancy rate is approximately 10% nationally. The College has calculated that an additional 1330 consultants will be needed to meet demand by 2028–2029 (Table 1), although the precision of the figures – for example a stated 89 required in older people's mental health – might be viewed as diminishing their reliability. A final challenge is retention of consultants. The ongoing enormous problem of the NHS pension scheme punitively hitting more senior clinicians is leading to many dropping sessions and retiring early.

Conclusions

The UK population is growing and ageing. The proportion with multiple needs is increasing considerably. Figures specifically for mental illness show considerable predicted growth, and we are reminded that most affected individuals do not seek help: although much welcomed, de-stigmatising programmes are likely to generate further growth in

TABLE 1 Estimated additional consultant psychiatrist posts required by 2028–2029

Service type	Additional consultant psychiatrists required by 2029
Child and adolescent mental health (including eating disorders)	363
Perinatal mental health	10
Liaison mental health	220
Early intervention in psychosis	40
Community mental health	500
Older people's mental health	89
Forensic	47
Addiction	15
Intellectual disability	39
Medical psychotherapy	7
Total	**1330**

Source: data from Royal College of Psychiatrists (2019: p. 42).

need that is currently hidden. Although health spending increases are planned, something the British Social Attitudes survey shows that the public support (Evans 2018), the planned investment does not seem adequate to address the underlying need for healthcare. Things look worse for social care, and it is hard to disagree with the National Audit Office's reporting of it as a 'Cinderella service' (National Audit Office 2018). The staffing data for both are frankly grim.

Health and social care are not working together effectively. The existing models are too rigid, linear, discouraging of innovation and ill-equipped to deal with what they now face. There are organisational silos not adequately built around patient pathways. The proposed solution of 'integrated care' seems a rational way to begin to redress some of these problems, and obvious targets and synergies present themselves. Closer alignment of health and social care – including having public health and substance use closer to other healthcare services – seems inherently sensible. Better aligning physical and mental healthcare should help with the range of comorbidities that psychiatric patients have, and the mental health needs of those under other services. The appropriate recent focus on out-of-area and private sector placements would seem to offer an obvious target for more integrated services. Within an integrated model it is not just 'proximity' but culture that matters: for example the poor outcomes in cancer and diabetes in people with severe mental illness are due to problems with investigation and treatment as well as access to care, and psychiatrists will have roles advocating for those in their care and educating other professionals. For patients and carers, it seems a less disjointed model and promises better outcomes. The optimistic interpretation is that more 'tools' are being offered to clinicians for their patients.

'Cultural' challenges of integration

However, equally obvious challenges appear, not least the practicalities of aligning culturally distinct services and areas and having an integrated workforce with staff on different pay scales. With regard to 'upskilling' staff in integrated services, the phrase 'new ways of working' is not one that endears itself to most psychiatrists, and staff rightfully worry about role substitution, deprofessionalisation and loss of specialist skills. Most discussion involves adults' and older peoples' health and social care services, yet we know how most mental-health issues begin in childhood and adolescence. There has been far less discussion about any integration between children's and adults' services, and here service cultural differences might be even greater to bridge. Further, this discussion so far has focused on secondary care, whereas 90% of mental illness remains looked after in primary care (we address primary care networks (PCNs) in parts 2 and 3).

Inequities between sectors

The multiyear staggering of healthcare funding increases the risk of acute emergency presentations and physical health services disproportionately taking money from preventive work on lifestyle factors, planned care and mental health. Further, existing preventive work tends to focus on physical health, and there is a gap in such work in mental health – again, particularly with younger people, whose trajectories are potentially most amenable to amelioration. The long-delayed green paper on social care is desperately needed, and it is very difficult to take long-term perspectives without understanding its future funding; enhanced funded is required, but from where? Aligned budgets also risk pulling money from health to social care.

Social factors remain core drivers of need and inequity. The King's Fund has argued that even if adequately resourced and aligned, health and social care alone cannot solve these problems without link up with wider socioeconomic, cultural and environmental factors (Buck 2018). It categorised the four 'pillars' of a true population health system as: integrated health and social care; places and communities we live in; our health behaviours and lifestyles; and wider determinants of health such as income, environment and education. Finally, whatever one's political stripe, these are undoubtedly uncertain times with much potential for rapid unforeseen social and economic changes affecting both demand and supply.

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What it might mean for you

If you are a mental health professional, these demographic, clinical, financial and workforce issues will affect you. There will be growth in demand on your service, which is unlikely to be matched by funding increases, and maintaining even existing staffing levels seems unlikely. The NHS Long Term Plan is starting to deliver structural service changes that will have an impact on your team and how it engages with other services. In part 2 we detail what these changes might look like, and in part 3 we suggest models and challenges in delivering integrated services and why clinicians – you – should be engaging with such change. Change can be difficult, but there is potentially much to gain in integrated care: we have new opportunities to work in ways that are centred on our patients, their lives and their often-multiple needs – something that we have all long called for.

MCQ answers
1 c 2 a 3 e 4 b 5 d

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MCQs

Select the single best option for each question stem

1 According to current estimates, by 2035, the number of people in England living with four or more illnesses (multi-morbidity) has been forecast to:
- a double
- b remain the same
- c quadruple
- d reduce by half
- e triple.

2 In the upcoming decade, demand growth is most likely to be increased in the following mental health cluster:
- a cognitive impairment and dementia
- b common mental health problems
- c severe psychotic depression
- d first-episode psychosis
- e non-psychotic chaotic and challenging group.

3 Which of the following statements regarding regional health inequalities in England is false?
- a those in poorest areas of England die an average of 7 years earlier than the richest
- b those in the poorest areas spend 17 additional years in disability
- c mortality from cardiovascular diseases is four times more common in those living in deprived areas
- d those in deprived areas are twice as likely to die prematurely from cancer
- e the health inequality gap in cardiovascular disease related mortality has decreased since 2010.

4 The NHS Long Term Plan commits to increase NHS England's budget by the following amount for the next 5 financial years:
- a 1.4%
- b 3.4%
- c 5%
- d 2.6%
- e 4.2%.

5 Which of the following statements is false?
- a adverse childhood experiences are linked with long-term physical and mental health problems
- b in 2018 there were 100 000 unfilled posts in the NHS
- c individuals with mental health problems face increased problems with housing
- d spending on alcohol and substance misuse are ring-fenced centrally
- e Royal College of Psychiatrists' estimates suggest that an additional 1330 consultants will be needed to meet demand by 2028–2029.

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