PLANNING FOR PREVENTION

Unlocking the potential of Integrated Care Systems to create a mentally healthy society

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MENTAL HEALTH FOUNDATION

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Glossary

Health and Care Act 2022

This Act set out major changes to the NHS in England, intending to improve the system by joining up the NHS, social care and public health services at a local level. It set up Integrated Care Systems on a statutory basis (see below).

Integrated Care Board (ICB)

One of the components of Integrated Care Systems (see below). They are responsible for governance of the system, and must include a chair, chief executive, and three other members drawn from NHS trusts and NHS foundation trusts, general practice and local authorities, and at least one person with knowledge and experience of mental health services, including preventative services.

Integrated Care Partnership (ICP)

One of the components of Integrated Care Systems set up to co-ordinate local agencies, the voluntary sector and others in developing an Integrated Care Strategy for the Integrated Care System.

Integrated Care Strategy

This sets out how the health and care needs in a local population (as determined in a Joint Strategic Needs Assessment) can be met by the Integrated Care Board.

Integrated Care System (ICS)

A local system set up by the Health and Care Act 2022 to help improve the health of the local population. There are 42 Integrated Care Systems in England.

Joint Forward Plan (JFP)

A five-year plan prepared by an Integrated Care Board setting out how it will meet its population's health needs.

Joint Strategic Needs Assessment (JSNA)

A process whereby local leaders work together to develop an understanding of the health needs of their local population in order to create a joint health and wellbeing strategy setting the priorities for collective action. This strategy is likely to overlap with the Integrated Care Strategy (see above).

Mental health

The World Health Organization defines mental health as 'a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.'[1]

Office for Health Improvement and Disparities (OHID

Part of the Department of Health and Social Care, responsible for improving the health of the population, with a particular focus on preventing health disparities (i.e. differences in health among particular communities and in particular places). It was set up after Public Health England was disbanded in 2021, taking on some of its former responsibilities.

Public mental health

The sustainable, co-ordinated improvement of mental health and promotion of mental wellbeing and resilience within the population, through preventative work involving communities, organisations and individuals, which also addresses the social and economic drivers of poor mental health and includes a particular focus on those at greatest risk of poor mental health. Sometimes policymakers and mental health systems speak about 'mental health prevention' (i.e. the prevention of mental health problems). This is largely synonymous with public mental health when the term 'prevention' is understood to refer to primary, secondary and tertiary prevention.

Task-sharing

The approach of sharing some mental health 'tasks' (e.g. screening, active listening and sometimes elements of treatment) with workers who are not traditionally thought to be part of the mental health workforce. This might include, for example, people employed in the voluntary sector whose focus is more on emotional support and active listening. This approach can allow more specialist mental health workers, such as psychologists, to spend more of their time working on specialised tasks.

Voluntary, community and social enterprise sector (VCSE)

An important partner for statutory health and social care agencies that plays a key role in improving health, wellbeing and care outcomes,[i] helping to ensure that public services are responsive to local needs. Analysis carried out under the previous government found that the sector plays a crucial role in the delivery of 'smarter, more thoughtful and effective public services that meet the needs of people across the country', and that it 'contribute[s] to economic growth, making the economy more innovative, resilient and productive'.[2]

Executive summary

Overview

Poor mental health remains the biggest single contributor to disability in the UK. Levels of poor mental health are unacceptably high and have been rising since 2000.[i]

There is strong evidence that preventative mental health work leads to social and economic benefits across society. The Foundation's 2022 report with the London School of Economics, *The economic case for investing in the prevention of mental health conditions in the UK*, put the economic and social costs of poor mental health at a conservative £118bn a year and set out some of the best value-for-money public mental health interventions. It is a human and an economic necessity that these be made widely available in our communities.

Yet public health is poorly funded, and public mental health even more so (it receives only around 3 per cent of specific local authority public health funding). The 2023 Hewitt Review noted a failure to realise the 'best health value' from current investment in the NHS and concluded that greater value can be achieved by investing in primary and secondary prevention, and by shifting care from acute to community and primary care settings.

The 42 Integrated Care Systems (ICSs) in England connect local authorities, the NHS, the voluntary sector and others. Now placed on a statutory footing by the Health and Care Act 2022, their remit is to improve the health and wellbeing of their populations. In commissioning and providing services, NHS bodies and their partners must also address inequalities and have regard to the sustainable and efficient use of resources. **ICSs represent an important opportunity to achieve this vital shift towards prevention**.

Despite its welcome and thorough guidance on Integrated Care Strategies, there is very limited action by central government to make this a reality. Neither is it scrutinising the extent to which ICS's strategies and plans set out actions to improve the public's mental health with work to prevent mental health problems, reduce their associated impacts and promote mental wellbeing and resilience.

Aims and methodology

In the absence of such scrutiny from the centre, our project aimed to examine the extent of the commitment to public mental health activity in the 42 ICS areas across England, by analysing their statements of intent in their 2023 Integrated Care Strategies and their Joint Forward Plans (JFPs) for the period 2023–28.[ii]

The strategies and plans were evaluated against criteria specifying or indicative of public mental health-related activities: the strategies for their intent to engage in public mental health activity, the plans for determining if they took a public mental health approach by addressing the social determinants of mental health and/or proposing mental health prevention work.

We also had a particular focus on the four population groups at heightened risk of poor mental health that are current strategic priorities for the Foundation: children and young people at risk of developing mental health problems, vulnerable families, asylum seekers and refugees, and people with long-term conditions.

i. For further information about levels of poor mental health and its impact on population disability see the NHS website: https://www.england.nhs.uk/mental-health/adults/ (accessed September 2024) and BMA analysis: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis (accessed September 2024).

ii. When the research took place between March and December 2023, two Integrated Care Strategies were not publicly available for review.

Findings

This report does not aim to 'call out' poor performance. It makes a broad assessment of the extent of public mental health activity in the 42 ICS areas, and highlights where particular ICSs have been able to make progress, for the purpose of sharing it with policymakers and others.

Our analysis found that many ICSs, but not all, are taking real steps towards preventing mental health problems and their associated impacts and promoting mental wellbeing and resilience.

The nature and extent of public mental health activity is variable, and it was rare for JFPs to set out explicit actions on prevention and early intervention. Indeed, even the best plans and strategies we reviewed would have benefited from more clarity on their approach to preventing mental ill-health. We also set out in this report the lack of a public mental health infrastructure in this country; there is no real plan from central government that sets out what the expectations are from all parts of the system, national and local, and provides the funding, leadership and knowledge-sharing to allow this to happen.[iii]

Overall, we identified **six** JFPs **(14%)** as being excellent and **eight (19%)** as being poor. The majority – **28 (67%)** – had good features but either did not constitute a detailed plan or were limited in the population groups they sought to support.

In relation to the Foundation's priority population groups, we found that:

- **every** ICP JFP includes at least some content on improving the mental health of children and young people;
- **37 (88%)** spoke about supporting vulnerable families;
- **20 (48%)** spoke about supporting people with long-term conditions;
- **only 11 (26%)** spoke about supporting the mental health of asylum seekers; and
- **only 6 (14%)** spoke about all four of these at-risk groups.

Encouragingly, racial inequalities in mental health were broadly understood within five-year forward plans. Less positively, only a minority had clear actions for addressing racial inequalities as a route to improving population mental health: **14 (33%)** met this criterion.

We found that only **three (7%)** ICSs mentioned specific mental health needs assessments (beyond the Joint Strategic Needs Assessments (JSNAs) that all local authorities carry out). Of these, **two (5%)** described how the assessment was being used to determine their planning. **None** stated how they would monitor the outcomes of public mental health interventions related to the mental health needs assessment. While JSNAs may in some areas contain substantial content on preventative mental health, a specific mental health needs assessment could be of value in areas where such content does not exist in order to galvanise action.

iii. See Table 1 on page 19.

Discussion and recommendations

NHS Confederation research has found a strong desire on the part of system leaders to move towards greater integration and a preventative model, but it has also identified that systemic issues around funding, social care delivery, workforce and capital are holding them back.

Given these challenges, it is not reasonable to expect local systems to excel at public mental health delivery when they are struggling to deliver on other core responsibilities. One of the most effective basic steps that central government could take to improve public mental health provision would be to address the funding and workforce issues that understandably occupy so much bandwidth for local decision-makers. This would free their hands to engage in the long-term, innovative prevention work that system leaders want to achieve.

To achieve a sustained shift towards prevention work, we recommend the following:

1 ICSs should develop rigorous plans on public mental health.

These should explicitly talk about public mental health and make this central to their strategic approach and mental health-related practice. Their plans should commit to well-evidenced programmatic work, embedding a trauma-informed approach across the system, and be informed by and responsive to community needs, especially for those most at risk of poor mental health.

Delivery of these plans must be supported by sufficient, long-term funding from central government (see Recommendation 5).

2 Better sharing of effective practice.

As public mental health work in ICSs develops, it will be critical for ICSs to share information about what is working most effectively in their areas. NHS England (NHSE), the Department of Health and Social Care (DHSC), the Ministry of Housing, Communities and Local Government, other central government departments, the Local Government Association, the Association of Directors of Public Health, the NHS Confederation and others should consider how they can facilitate effective sharing of good practice.

3 ICSs need a stronger focus on minoritised communities.

They should develop clear plans to improve the mental health of all the minoritised communities in their areas, including the inclusion health groups.

4 Central government must create a new public mental health infrastructure.

This must address the determinants of mental health and enable delivery of evidence-based public mental health work in a planned, sustained, accountable way, with clear targets and a roadmap for delivery. We have set out details of the necessary components of such an infrastructure in this report.

5 Central government must increase funding for prevention.

Long-term funding is needed for public mental health work. The government should introduce a full national needs assessment of the implementation gap in public mental health, and ensure funding is in place to deliver the work needed to address this. Part of this will involve the restoration of the public health grant to at least the 2015 level.

As the Hewitt Review (2023) recommends, this requires a shift in resources; we support the review's proposal that the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1 per cent over the next five years. This requires national funding support.

We are supportive of Demos' call for a new category within Departmental Expenditure Limits – Preventative Departmental Expenditure Limits – which has the potential to rebalance the way we consider expenditure as a country and allow us to take longer-term decisions. Funding for prevention should be ring-fenced, with oversight to ensure that it is genuinely used for that purpose.

6 Better collaborative working between the centre and ICSs.

We need more co-production of national policies and guidance, with ICSs and NHSE working together to develop them. They should recognise the deep impact of inequality on mental health, and prioritise action aimed at minoritised communities, people living in poverty and others, such as the 'inclusion health groups', whose needs have historically been underserved. Such collaboration must be fully inclusive, involving the voluntary, community and social enterprise sector and other sectors, communities and people with lived experience.

7 Mental health and wellbeing policy and spending impact assessment.

The UK government must fulfil the commitment made under the previous government's interim Major Conditions Strategy report (for England) to develop a Mental Health and Wellbeing Impact Assessment Tool to support policymakers to consider the mental health and wellbeing effects of their policies.

In addition, the mental health implications of spending decisions should be introduced as new criteria in the Treasury's Green Book and accompanying guidance.

8 An increased focus on children and young people.

Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. Well-evidenced prevention and early intervention programmes exist to prevent a range of adverse outcomes, including having mental health problems as an adult. DHSC, the OHID and NHSE should work with local systems to ensure widespread availability of these cost-effective programmes shown to improve infants', children's and young people's mental health. This should include digital interventions; children and young people need the option of accessing effective support in ways that work for them, at any time.

Every parent and carer should have access to effective support, including evidence-based parenting programmes, and every school and college should be a mentally healthy place for children and young people.

9 A national cross-departmental inequalities strategy.

The government should develop a cross-departmental strategy to reduce health inequalities, focusing on reducing inequalities in the population that cause people to become unwell in the first place, and preventing the range of inequalities that can arise from having a mental health problem.

10 Action to address wider systemic issues.

System leaders have a strong desire to move towards greater integration and a preventative model, but issues around funding, social care delivery, workforce and capital are holding them back. To help enable the move to more preventative work, the government must address these wider challenges facing the NHS and local authorities.

The report also sets out recommendations for further research that the government should undertake to support this work, including research that improves the evidence base on public mental health interventions and quantifies the current resource allocation for such interventions, and promotes a better understanding of mental health inequalities and levels of need.

Introduction and background

The Mental Health Foundation's vision is good mental health for all. Everyone and every type of organisation has a role to play in making this vision a reality, with local and regional government, and at a national level the Department of Health and Social Care (DHSC), the Ministry of Housing, Communities and Local Government (MHCLG) and NHS England (NHSE), having particular responsibilities for improving the population's mental health. Other government departments also play an important role in addressing the social determinants and inequalities that affect people's mental health. The Foundation advocates a 'mental health in all policies' approach for creating the social and economic conditions in which people can thrive.[3]

Following the health reforms of 2011 ('the Lansley reforms'), the NHS developed a number of informal arrangements for working as effectively as possible within the legislative framework they created. This was necessary because the systems created by the reforms were unsuited to the type of strategic partnership working that was required. This process of local reconfiguration led to many areas developing local partnerships to co-ordinate work, called Sustainability and Transformation Partnerships (STPs). These aimed to connect the NHS, local government and others to deliver better care and support for their populations, and evolved into Integrated Care Systems (ICSs).

Recognising the power of these local arrangements and the potential they offered, the government legislated through the Health and Care Act 2022 to put them on a statutory basis.[4]

These reforms are welcome, and they aim to put prevention of poor health at the heart of local practice. More detail about what this means for prevention and public mental health activity is provided in Chapter 1: Policy Context.

But there is limited oversight of how public mental health is being addressed within the new systems, and work remains patchy and rarely funded. Reasons for this include: a lack of knowledge of what is effective, how it can be implemented within systems and who is responsible for funding it, as well as the challenges of funding prevention work in the context of pressing acute care needs. In this report, we have sought to develop an understanding of some of the key activities relating to public mental health that systems are carrying out.

We have concentrated particularly on areas where the Foundation has a strategic focus: reducing the social and economic inequalities affecting people's mental health, and some of the population groups at greater risk of developing mental health problems: asylum seekers and refugees, people with long-term conditions, and children, young people and vulnerable families.

This report is intended to highlight what good practice can look like within local systems, and to help policymakers identify the structural and systemic challenges (such as workforce issues and lack of funding) to adopting and delivering comprehensive and sustained public mental health approaches and interventions in England.

Chapter 1: Policy context

Where mental health is concerned, there is a marked and longstanding national implementation gap: only a minority of people with a mental health condition in the UK receive treatment, far fewer receive interventions to prevent the associated impacts of having a mental health problem, and there is negligible coverage of interventions to prevent mental health problems or to promote mental wellbeing and resilience.[5] Improved implementation of public mental health interventions can result in broad health, social and economic impacts, even in the short term, which support the achievement of a range of policy objectives, sustainable economic development and recovery.[6]

The Health and Care Act 2022 set up Integrated Care Systems (ICSs) as new statutory bodies that connect local authorities, the NHS, the voluntary sector and others to improve the health of their populations. In this new arrangement, all the health and social care funding for the ICS area is administered by the Integrated Care Board (ICB). Historically, the overwhelming majority of these budgets have been spent on acute care, rather than on prevention.

Indeed, the 2023 Hewitt Review noted a failure to realise the 'best health value' from current investment in the NHS. The review draws on evidence from other healthcare systems as well as our own that demonstrates that greater value can be attained by 'allocative efficiency' – that is, by investing in primary and secondary prevention, and by shifting care from acute to community and primary care settings.[7]

ICSs represent an important opportunity to achieve this.

There are 42 ICSs across the country, whose population size varies from around 500,000 to around 3 million people.[8]

The 'triple aim' requires that NHS bodies which commission and provide services make decisions with regard to:

- the health and wellbeing of the people of England (including inequalities in their health and wellbeing);
- the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services); and
- the sustainable and efficient use of resources by both themselves and other relevant bodies.[9]

The Health and Care Act 2022 is clear that 'health' includes 'mental health', but 'wellbeing' remains a somewhat poorly defined and contested term. In government policy documents it is often used as a synonym for positive mental health or a catch-all term for improved social and health outcomes.

To provide greater clarity, it is helpful instead to consider two interrelated dimensions: mental health/mental health problems and mental wellbeing/resilience. This is a dual continuum, as both of these dimensions co-exist in any individual.[iv] If we have symptoms of a mental health problem, this will affect our mental wellbeing, and the promotion of mental wellbeing will both reduce the likelihood of developing mental health problems and promote recovery from mental health problems. In this regard, it is important to use evidence-based interventions to treat mental health problems and alleviate or prevent their associated effects, which will in turn improve wellbeing.

We recommend that the term 'public mental health' is used to refer to work in this area, as it is a well-defined term which can be more easily used to support the development of plans and for holding systems to account for improving population mental health.

iv. See Table 6 of *Public mental health: Evidence, practice and commissioning*, a report of the Association of Directors of Public Health, Faculty of Public Health, Health Education England, Local Government Association, Royal College of General Practitioners, Royal College of Psychiatrists (RCPsych) and Royal Society for Public Health (RSPH), available at the RSPH website: https://www.rsph.org.uk/static/uploaded/b215d040-2753-410e-a39eb30ad3c8b708.pdf (retrieved August 2024).

We define public mental health as *"the sustainable, co-ordinated improvement of mental health and promotion of mental wellbeing and resilience within the population, through preventative work involving communities, organisations and individuals, which also addresses the social and economic drivers of poor mental health and includes a particular focus on those at greatest risk of poor mental health. In this context, preventative work refers to primary, secondary and tertiary prevention."*

In practice, this involves the following:

- A mental health needs assessment, which is a statutory duty and a key element of public mental health practice.[10] This should include the level of unmet need for treatment of mental health problems, prevention of their associated impacts, prevention of mental health problems, and the promotion of mental wellbeing and resilience. Some local authorities prepare a specific mental health impact assessment beyond their Joint Strategic Needs Assessment (JSNA).
- ICPs fulfilling their duty under the Health and Care Act 2022 to set out how these assessed needs are to be met by the ICB, partner local authorities, the NHS and the Voluntary, Community and Social Enterprise (VCSE) sector through the Integrated Care Strategy.
- Ensuring effective dissemination and good multi-professional knowledge and understanding of the evidence base for public mental health.
- The delivery of evidence-based programmes that are shown to prevent mental health problems, by intervening as soon as they arise, preventing their associated impacts, and promoting mental wellbeing and resilience, all of which results in improved mental health. Examples of well-evidenced and cost-effective practice include anti-bullying programmes, better support in the perinatal period and parenting programmes.[vi]
- Listening to communities to understand what they need to improve their mental health, and taking an asset-based approach to understand the strengths within communities that can be built upon with careful and appropriate local government and health system support.[v]
- The continuing development of the evidence base by rigorously evaluating promising practice from the UK and overseas.
- Central and local government action to address the conditions and experiences known to be harmful to good mental health, including racism and other forms of discrimination, poor-quality housing, poverty and the commercial determinants of poor mental health, such as the promotion of alcohol consumption and poor-quality diets.[vii,11]
- Evidence-based work to encourage mental health literacy, awareness and self-care – for example, campaigns such as 'Every Mind Matters'.[viii]

The NHS and DHSC have supported ICSs to discharge their responsibilities by publishing several pieces of guidance. Of particular relevance to the discharge of their public mental health duties are the following:

- *Guidance of the preparation of integrated care strategies.* This sets out how the ICB, responsible local authorities and NHSE (when it commissions specialised services in the area) will meet the assessed needs identified in the joint strategic needs assessment produced by the health and wellbeing boards.[12]
- *Working in partnership with people and communities (Statutory guidance).*[13,ix]

v. More information on asset-based approaches can be found in our report *Tackling social inequalities to reduce mental health problems*, available at: https://www.mentalhealth.org.uk/sites/default/files/2022-04/MHF-tackling-inequalities-report.pdf (accessed September 2024).

vi. Evidence on the effectiveness of public mental health interventions is set out in the London School of Economics/Mental Health Foundation report *The economic case for investing in the prevention of mental health conditions in the UK (2022)*: https://www.mentalhealth.org.uk/explore-mental-health/publications/economic-case-investing-prevention-mental-health-conditions-UK (retrieved August 2024).

vii. Other commercial determinants of poor mental health include the aggressive promotion of gambling and the destabilisation of the climate by corporate action. The Royal College of Psychiatrists has produced resources on this emerging policy area: https://www.rcpsych.ac.uk/improving-care/public-mental-health-implementation-centre/pmhic-commercial-determinants-of-mental-health-(cdomh)-symposium (accessed July 2024).

viii. Information about the campaign is available on the NHS website: https://www.nhs.uk/every-mind-matters (retrieved August 2024).

ix. There is a significant further body of guidance for ICSs, some of which has relevance for public mental health. A full list is available on the NHS website: https://www.england.nhs.uk/publication/integrated-care-systems-guidance (retrieved August 2024).

These include measures that local systems should be taking to support the mental health of their population. Some of these are set out below.

Guidance on the preparation of integrated care strategies

This DHSC guidance sets out the purpose of Integrated Care Strategies and how they can best be drawn up. It does not use the language of public mental health throughout (containing only one reference to it), but it sets out a clear expectation that local systems improve the mental health and wellbeing of their populations, including through reducing inequalities by addressing the social determinants of poor mental health:

The integrated care strategy is intended to meet the needs of local people of all ages identified in the relevant health and wellbeing boards' joint strategic needs assessments [...] ICPs should use these assessments to explore gaps in care, unwarranted variation, and disparities in health and care outcomes and experiences between parts of the population and understand opportunities where system-wide action could be effective in improving these, including addressing the wider determinants of health and wellbeing, and preventing ill-health and future care and support needs.

It stresses the need for the voluntary sector to be involved:

VCSE organisations often offer a practical route to understanding the experiences of the groups who are most minoritised and whose voices are most seldom heard.

VCSE alliances, or similar entities, are present in each area, and will be important from the outset in the production of the integrated care strategy.

It also sets out how systems should work to deliver public mental health interventions:

ICPs should ensure the full utilisation of public health expertise and leadership, centring on the local directors of public health. The strategy should include measures to improve health and wellbeing outcomes and experiences across the whole population, including addressing the wider determinants of health and wellbeing.

Working in partnership with people and communities statutory guidance

This NHSE statutory guidance sets out the main legal duties on ICSs regarding working with people and communities, the reasons for doing so and some of the ways in which this can be accomplished. It also sets out 10 principles for working with people and communities, including:

- **Centr[ing] decision-making and governance around the voices of people and communities.**
- **Us[ing] community-centred approaches that empower people and communities, making connections [sic] what works already.**
- **Build[ing] relationships based on trust, especially with marginalised groups and those affected by health inequalities.**

It sets out the ambition for a health and care system that focuses on the voices of communities. While not going so far as to advocate a bottom-up approach to policy-making, it attempts to push systems to shift power further towards communities, setting out its intention to create a health service that 'listens more and broadcasts less', 'shares power with communities so they have a greater say in how health services are shaped and can take responsibility to improving their health' and 'is focussed on and responds to what matters to communities and prioritises hearing from people who have been marginalised and those who experience the worst health inequalities'.

It is important that needs assessments capture the coverage and outcomes of different types of public mental health interventions provided by different sectors and take account of the views of the local community, including from people in higher-risk groups.

The role of health systems as anchor institutions

In addition to programmatic public mental health work, ICSs have a role to play in creating the wider changes in society needed to create mentally healthy communities.

Much of this action will be the responsibility of the non-NHS partners in ICSs, including local authorities and the voluntary sector, and it may not initially be obvious what the NHS can do to address the social determinants of poor mental health directly. The chief way in which it can do this is by embracing its role as an 'anchor institution' – that is, a major part of the local community which is constantly taking decisions of social and economic relevance to the people living in its area.

The guidance on the preparation of Integrated Care Strategies states that systems should be working in this way, saying: "Integrated care strategies should explore the role that local government, NHS, other large employers, providers and partners can play as anchor institutions [...], and the potential to use their spending power and significant assets to benefit communities and enhance socio-economic conditions."

Use of estates

The NHS is one of the largest public landowners in the UK,[14] and there are opportunities for it to use its outside space to improve access to nature and its buildings to provide free access to community groups which support mental health (e.g. to address loneliness).

NHS Property Services has also done work on using NHS property to support social prescribing,[15] and the Health Foundation has written about how the NHS can work with local authority partners to develop good-quality, affordable housing using its vacant land.[16]

Social value procurement

The NHS can also do more locally to support its local economy through social value procurement. NHSE guidance on social procurement does exist[17] (including a requirement to weight these concerns by at least 10 per cent when making procurement decisions), but it is unclear to what extent it has been adopted. While the guidance does cover issues such as wellbeing and economic inequality, it has a stronger focus on achieving net zero. Clearly the latter is critical, not least for the mental health of the population, but should be approached in tandem with, rather than instead of, tackling broader social issues.

We are aware of work carried out on social value procurement by East London NHS Foundation Trust, which has been evaluated by the Strategy Unit (an NHS team which works on analysis and research). The analysis sets out useful learning and advice for other NHS bodies wanting to take a similar approach.[x]

Concerningly, though, work from the NHS Confederation showed that 34 per cent of system leaders are 'not very confident' or 'not confident at all' that they could help the NHS to support broader social and economic development.[18] The Confederation has published a toolkit on the topic, which leaders might find useful for increasing their confidence in meeting their goals.[19]

Inequalities

Mental health is an inequality issue.

Lower incomes are associated with poorer mental health and wellbeing. Socio-economically disadvantaged children and adolescents are two to three times more likely to develop mental health problems.[20] Mental health problems disproportionately affect groups that are minoritised by society, including Black people, LGBTQ+ people, people with disabilities, people with long-term physical health conditions and many other groups.

x. The evaluation is available on the Health Anchors Learning Network website: https://haln.org.uk/case-studies/social-value-procurement (accessed July 2024).

Another minoritised group with high levels of mental health need is asylum seekers and refugees, who are more likely to develop mental health problems because of the trauma they may have experienced in their home countries, on their journey to the UK or after arriving here, as well as the discrimination and impoverishment they face in this country.[xi]

It is also the case that mental health problems can have a broad range of impacts on an individual, including socio-economic inequalities.[21]

Addressing inequalities in mental health requires several co-ordinated strands of action by different sectors:

1. Action to tackle poverty and material deprivation, including housing.
2. Work at all levels of society, including ICSs, to tackle racism and other forms of discrimination throughout health systems, the public sector and society more broadly.
3. Retirement of policies that harm the mental health of minoritised groups – for example, the impoverishment of asylum seekers through the no recourse to public funds policy.
4. Targeted public mental health interventions aimed at minoritised and low-income people and communities, to buffer the impacts of their exposure to the social determinants of poor mental health.
5. Prevention of inequalities in people with existing mental health conditions which would otherwise be likely to arise.

Responsibility for points 1 and 2 sits with both central government and local systems, including ICSs. Responsibility for the fourth point sits largely with ICSs, yet it is not clear that there is substantial work taking place across the country to make this a reality.

The government's guidance on the preparation of Integrated Care Strategies explicitly states that ICPs should be engaging with the most minoritised groups when developing their strategies:

ICPs should consider how a wide range of people are able to engage and input into the strategy. This should include, but is not limited to, proactively involving people with a range of lived experiences of accessing health and/or social care services, including:

- children in care and care leavers or having a mental or physical health condition
- seldom heard voices (such as, but not limited to, children and young people, asylum seekers, refugees, and people with English as a second language)
- people experiencing, or at risk of, homelessness.

It also asks ICSs to consider the drivers of poor health outcomes, including among the most minoritised groups:

ICPs should consider how their integrated care strategy will address unwarranted variation in population health and disparities in health and wellbeing outcomes, access and experience from conception through to end of life. This should also address the drivers of these variations and disparities. In addition, certain groups, such as refugees and asylum seekers, inclusion health groups or people with trauma from violence or abuse [...], can face multiple disadvantage and multiple barriers to accessing the health, care and support they need. Strategies could include a focus on what specifically could be done to join up services for those experiencing significant and multiple disadvantage to facilitate better outcomes, access and experience. This could include, for example, health, care and housing and other wider determinants of health.

This is echoed in the statutory guidance on working with people and communities, which states:

By building engagement approaches that include people who are currently not well supported by existing services, systems can design models of care that meet the needs of all their communities and address inequalities. This includes recognising that some communities may require different approaches to meet their needs. Population groups facing the worst health inequalities are often the

xi. We have set out the evidence and policy recommendations on asylum seekers and refugees in our report *The Mental Health of Asylum Seekers and Refugees in the UK* (reference 47).

most disempowered, with the lowest levels of various markers for control, belonging and wellbeing. Working with the most marginalised groups needs to be based on building trust and connection as an important foundation for improving their health outcomes.

It goes on to set out the need to address the mental health needs of the 'inclusion health groups' – that is, the groups which experience the worst mental health inequalities. These groups include vulnerable migrants and refugees, people experiencing alcohol and drug dependence, and young carers.[xii]

The guidance emphasises that:

It is essential to understand the barriers that the system inadvertently creates to the involvement of inclusion health groups. Approaches should be developed in partnership with trusted organisations and people with lived experience and seek to ensure that involvement means that people's voices are heard and understood. These may be national organisations where there is not the local expertise of working with specific groups. Approaches must be trauma informed [...], culturally aware and provide a psychologically informed environment for people to take part safely.

Promisingly, 2023 research by the NHS Confederation showed that tackling inequalities ranked as the primary ambition leaders would like to have achieved in five years' time. Concerningly, though, one in five ICSs said that they did not feel confident in their ability to tackle inequalities, and none of them were 'very confident'.[22]

Its research also highlighted different views about where the focus should be on tackling inequalities: on healthcare, or on health, including its social determinants. It is concerning that policymakers and system leaders continue to lack clarity on what reducing inequalities means in practice, and what ICSs' roles are in this. The NHS Confederation advocates for the development of a shared understanding of inequalities, and sets out some ways of doing this.

This research also found that '*leadership, governance and relationships were enablers for success in health inequalities. The biggest barrier that systems reported overcoming was balancing long-term strategic priorities with short-term operational must-dos.*'

The report makes specific recommendations on governance to address health inequalities and notes that:

The creation of specific committees and work groups responsible for developing strategic approaches for addressing inequalities, with direct lines of reporting into the board, was a key enabler to action on health inequalities.

Local systems should also be working in line with NHSE's Advancing Mental Health Equalities programme (AMHE) and the Patient and Carer Race Equality Framework (PCREF), as well as its Core20PLUS5 agenda.

Advancing Mental Health Equalities

In England, only a minority of people with a diagnosed mental health problem receive treatment, and far fewer receive any intervention to address and prevent its associated impacts. This implementation gap is even greater for higher-risk groups, which breaches both legislation relating to public mental health and the Equality Act 2010.[23]

NHSE's AMHE strategy aims to address inequalities in access, experience and outcomes in mental health care. Its three key strands are:

- supporting local health systems to advance equalities;
- improving the quality and use of data to inform decision-making; and
- creating a diverse and representative workforce which is equipped with the capabilities to achieve change.[xiii]

xii. The guidance also notes the following groups: Gypsies, Roma, Travellers, Showmen and Liveaboard Boaters; sex workers; victims of modern slavery; people in contact with the criminal justice system.

xiii. See website: https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities (accessed August 2024).

Part of AMHE is the PCREF,[xiv] which is a mandatory framework intended to 'support trusts and providers on their journeys to becoming actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services'.

Core20PLUS5

Core20PLUS5 is an NHSE programme aimed at addressing healthcare inequalities. It aims to focus action on areas of particular inequality:

- **Core20** – the most deprived 20 per cent of the population;
- **PLUS** – facing inequalities that groups defined at a local level, which might include, for example, people from Black and minority ethnic communities, people with learning disabilities and people with multiple long-term health conditions; and
- **5** – five areas of clinical focus which require accelerated improvement, including maternity and severe mental illness.

Though its focus is clinical, it has relevance to preventative mental health work, in particular for maternity services, and for tertiary prevention for people with severe mental illness (SMI), who should also be an important focus.[xv] While people with SMI represent a minority of people with mental health problems, many severe mental health problems have a significantly reduced life expectancy, which is a major inequality.[24]

National support for public mental health work in ICSs

There is very welcome and thorough guidance for ICSs on implementing an equitable and preventative approach to mental health problems covering all levels of prevention, the prevention of their associated effects (including through treatment) and the promotion of mental wellbeing and resilience.

Yet there is very limited action by central government to make it a reality. There is no central government oversight of the ICSs' work to prevent mental health problems, and minimal funding available for them to do this.

The funding that has been available in recent years for public mental health programmes includes:

- The public health grant, paid to local authorities, worth £3.603bn in 2024–25.[25] This covers all public health expenditure, and only a small proportion is used for public mental health: in 2022 this was £110.7m – that is, around 3 per cent of the total funding[26,xvi]
- Suicide prevention funding of £57m over three years, paid to local authorities. This was not renewed in the 2024 Spring Budget.

In 2022/23 and 2023/24, £200m was ring-fenced for systems to use to tackle inequalities. This ring-fence has now been removed, and it remains to be seen how much will continue to be used for this purpose.

Nationally, the government has run the Prevention Concordat for Better Mental Health, which has not received specific funding, and Every Mind Matters, which received national-level funding of £3.35m in 2023/24.[xvii]

xiv. See website: https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref (accessed August 2024).

xv. See website: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5 (accessed August 2024).

xvi. Though this proportion of spend is small, Local Authorities have been successful in growing it significantly in recent years; in 2016/17 the figure was just £53.1m (adjusted for inflation). Local authorities will often also fund public mental health work from other parts of their budget, meaning that this figure should not be taken to be the total national expenditure.

xvii. Figure given by Maria Caulfield MP in response to a parliamentary question: https://questions-statements.parliament.uk/written-questions/detail/2024-05-07/24989 (accessed August 2024).

It appears that central public mental health capacity available in the Office for Health Improvement and Disparities (OHID) has been cut, though the government has not been transparent on changes in staffing levels even when asked directly.[xviii] This is despite the fact that preventative mental health work leads to economic and social benefits across society. Our report with the London School of Economics and Political Science, *The economic case for investing in the prevention of mental health conditions in the UK*, put the economic and social costs of poor mental health at a conservative £118bn a year, and set out some of the best value-for-money interventions to protect the public's mental health.[27,xix]

ICSs have a challenging task in delivering public mental health interventions. They have very small amounts of money to do so, and lack support and oversight from the centre. Public mental health is an embryonic discipline, and sharing information on what is working effectively will be fundamental to increasing delivery in an environment of extremely limited funding.

And importantly, ICSs in the poorest areas will have a higher burden of need compared with those in the richest, given the well-evidenced link between the social challenges faced by populations and their mental and physical health.[xx] This means that those systems where public mental health interventions are most needed are likely to have the least resources to deliver them.

It is interesting to note that during the pandemic – when it was widely understood that the whole population was at risk of worsening mental health – these greater mental health needs were recognised. The then government's Covid-19 mental health and wellbeing recovery action plan identified £15m to be invested in the most deprived local authority areas in England, to:

> **[…] help stimulate and boost prevention and early intervention services to support those hardest hit by the pandemic. This include[d] families who [were] experiencing significant challenges, children and young people, and ethnic minority groups.**[28]

This was not a huge amount of funding, and it was strictly time-limited, but evaluation of the work it led to showed what sustained public mental health work could achieve for communities and is a helpful resource for ICSs.

The evaluation identified that up-to-date JSNAs and other robust needs assessments were a vital foundation for the work, providing insight about where the needs were greatest and the gaps most pronounced. It was also clear that areas with an existing strategic focus on addressing inequalities were more readily able to implement a coherent and co-ordinated programme of activities. Importantly, it showed that funding for public mental health activity can make a marked difference by building social and community capital. This was especially so for smaller organisations, particularly if the funding was disbursed flexibly, enabling a rapid response to identified need and reducing administrative burden.[29]

Given that ICSs face the systemic challenges set out above, this report does not aim to 'call out' poor performance. Instead, it makes a broad assessment of the extent of public mental health activity in the 42 ICS areas, and highlights where particular ICSs have been able to make progress on public mental health, for the purpose of sharing it with others.

xviii. See, for example, the answer given to a parliamentary question on this topic by Maria Caulfield MP: https://questions-statements.parliament.uk/written-questions/detail/2024-05-07/24988 (accessed August 2024).

xix. See also Tables 9 and 10 of Campion, J. (2019). Public mental health: Evidence, practice and commissioning. Royal Society for Public Health. Retrieved from: https://www.rsph.org.uk/static/uploaded/b215d040-2753-410e-a39eb30ad3c8b708.pdf (accessed August 2024).

xx. See, for example, the Health Foundation's evidence hub on social factors and physical health, available here: https://www.health.org.uk/evidence-hub/health-inequalities (retrieved August 2024) and the Mental Health Foundation's work on the social determinants of mental health: *Tackling social inequalities to reduce mental health problems: How everyone can flourish equally*, available here: https://www.mentalhealth.org.uk/sites/default/files/2022-04/MHF-tackling-inequalities-report.pdf (retrieved August 2024).

Table 1: The UK's public mental health infrastructure – where are we now?

System level	Component	Status
Central government	Funding to local systems for prevention	Public health grant (which covers mental and physical health) cut by £1bn since 2015[xxi]
	Accountability framework	Not in place
	National leadership, expertise and capacity on public mental health	Significantly reduced
	Cross-government plan to tackle social determinants of mental health	Abandoned
	Access to public mental health training	Minimal
	Specific, ring-fenced funding for ICSs for the prevention of mental health problems	Non-existent
	Specifically funded support for children and young people	Partial – for example, through Mental Health Support Teams and family hubs
	Government-funded research into the most effective public mental health interventions	Minimal
Integrated care systems	Targeted, evidence-based programmes in place for those most in need	Minimal
	Local efforts to tackle the determinants of poor mental health	Partial
	NHS using its status as an anchor institution to address health inequalities	Partial

xxi. Adjusted for population increase and inflation. Using different calculations, the National Audit Office puts the cut at a slightly lower level: £846 million in real terms, a 20.1% reduction. See National Audit Office (2024) NHS Financial Management and Sustainability Department of Health & Social Care, NHS England https://www.nao.org.uk/wp-content/uploads/2024/07/nhs-financial-management-and-sustainability.pdf (accessed August 2024).

Chapter 2: Public mental health planning in ICSs

Methodology

This project aimed to scope the commitment to public mental health activity in ICSs across England, through examining their statements of intent in their publicly available policy documents. We conducted the work in two stages: first we examined the 42 Integrated Care Strategies published in 2023, and then we assessed their five-year JFPs (for the period 2023–28). For both stages we summarised the data according to specified criteria indicative of public mental health-related activities.

Integrated Care Strategies

All publicly available strategies were read and evaluated for their intent to engage in public mental health activity.[xxii] This meant looking not only for the obvious terminology – 'public mental health', 'prevention of mental ill-health', 'primary prevention' and so on – but also for mention of activities that would constitute such initiatives, such as investment in improving the social determinants of mental health and programmes to support mental health in the community. We recorded our findings using a combination of summary text and direct quotations. The criteria under which they were grouped are listed in Appendix 1, and include the following areas of overall interest:

- Are there any specific mentions of the term 'public mental health', or descriptions of public mental health activity articulated less directly?
- Is importance given to primary prevention – namely, taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups?
- Is importance given to secondary prevention – that is, systematically detecting the early stages of disease and intervening before full symptoms develop?
- Is tertiary prevention mentioned – that is, interventions for people who already have mental health problems which promote mental wellbeing and recovery and minimise disability?
- Does the strategy demonstrate an understanding of the fact that social determinants affect mental health – both positively and negatively – as well as physical health, and can create mental health inequalities?
- Is there a commitment to improving population mental health/wellbeing?
- Does the strategy mention specific public mental health interventions?

Joint Forward Plans

A similar approach was adopted for the JFPs. Each plan was examined in detail to determine whether it took a public mental health approach by addressing the social determinants of mental health and/or proposing mental health prevention interventions. Again, the areas of focus are listed in Appendix 1, and included the following:

- A recognition of the wider determinants of mental health
- Noting or discussion of the social and community context affecting people's mental health
- The prominence of mental health/wellbeing within the plan
- Reference to the features of the population/health inequalities

xxii. When the research took place, between March and December 2023, two integrated care strategies were not publicly available for review.

- General mental health prevention plans
- Plans for improving the mental health of children and young people
- Plans for people with severe mental health problems.

In each case, we gave a narrative summary of the quality of the plans, defined as the extent to which the ICS appeared to be seriously engaged with public mental health. This enabled us to select case studies for more in-depth examination.

In addition to the above, we focused particularly on the four population groups that are current strategic priorities for the Mental Health Foundation:

- Children and young people at risk of developing mental health problems
- Vulnerable families
- Asylum seekers and refugees
- People with long-term conditions

We also noted work aimed at improving the mental health of people from Black communities, given the continuing and major inequalities they experience, including the impact of racism in the community and in the mental health system.[30]

There are of course other groups which experience significant health inequalities, including homeless people, members of the Gypsy, Roma and Traveller communities, members of the LGBTQ+ communities and sex workers. We considered efforts to work with these communities in the case studies in Chapter 3, but further research is needed to establish the extent to which ICSs as a whole are prioritising these groups.

The figures given below for coverage of particular areas in systems' plans focus on their JFPs, as their presence in these documents is more likely to indicate that action is being actively planned with the clear intention to deliver it, as compared with commitments that only appear in the system's strategy.

Limitations

- Assessment of the quality of the public mental health plans of ICSs looked at what they said about their activities and planned work. We were not able to analyse the delivery of these activities.
- Strategies and plans were inconsistent in their presentation of data and content, resulting in a potentially inconsistent examination of their contents.
- A small number of the JFPs were published solely online. This was problematic for our methodology, as it necessitated searching a number of separate web pages and prevented the use of page-number referencing. This might also make it more difficult for ICB partners, other organisations, communities and individuals with an interest in interrogating and using the plans to do so easily.
- There may be further information on ICS plans set out in their JSNAs and joint local health and wellbeing strategies that has not been captured by this research.
- Additionally, local authorities' suicide prevention plans include activities to reduce the incidence of suicide in higher-risk groups, and much of this activity can be considered to be public mental health activity. For example, a 2019 analysis of the plans found that 92 per cent included action to improve the mental health of children and young people, and 80 per cent of these planned actions were being delivered.[31] However, these plans fall outside the scope of this analysis, so have not been included.

Findings

- Every ICS JFP includes at least some content on improving the mental health of children and young people.
- **37 (88%)** spoke about supporting vulnerable families.
- **20 (48%)** spoke about supporting people with long-term conditions.
- **Only 11 (26%)** spoke about supporting the mental health of asylum seekers.
- **Only 6 (14%)** spoke about all four of these at-risk groups.

We found that racial inequalities in mental health were broadly understood within five-year forward plans, but only a minority had clear actions for addressing racial inequalities as a route to improving population mental health: **14 (33%)** met this criterion.

We identified **six** JFPs **(14%)** as being excellent, and **eight (19%)** as being poor. The majority – **28 (67%)** – had good features but either did not constitute a detailed plan or were limited in the population groups they sought to support.

We found that only **three (7%)** Integrated Care Systems mentioned specific mental health needs assessments (beyond the JSNAs that all local authorities carry out).[xxiii] Of these, **two (5%)** described how the needs assessment was being used to determine their planning. **None** stated how they would monitor the coverage or outcomes of public mental health interventions related to the mental health needs assessment. While JSNAs may in some areas contain substantial content on preventative mental health, a specific mental health needs assessment could be of value in areas where it does not exist in order to galvanise action.

We estimate, based on the populations of the ICSs whose plans are less detailed, that **10 million people** are living in an area where plans for improving the public's mental health are insufficient.

We identified the following plans and strategies as being particularly strong:

1. Bath and North East Somerset, Swindon and Wiltshire ICS
2. Dorset ICS
3. Frimley ICS
4. West Yorkshire ICS

We therefore carried out detailed analysis of aspects of these areas' plans and strategies, which is summarised in Chapter 3 below.

Other sector analysis of Integrated Care Strategies and JFPs

Research by the Children and Young People's Health Policy Influencing Group (HPIG) found similar variations in Integrated Care Strategies and plans. Their analysis of 31 of the 42 systems found that:

- only **6 per cent** of strategies and **17 per cent** of the 31 JFPs they assessed stated how children and young people had influenced their work; and
- children with major and long-term conditions were absent in the majority (59%) of these 31 strategies.[32]

Research carried out by the NHS South, Central and West (SCW) Commissioning Support Unit into the extent to which Integrated Care Strategies and JFPs addressed inequality found that: 'There was a good level of evidence provided for people who experience homelessness; drug and alcohol dependence, and vulnerable migrants but there was limited /no coverage of other inclusion health groups such as victims of modern slavery and sex workers etc.'[33]

Their more positive finding on vulnerable migrants contrasts with our own analysis of support for asylum seekers and refugees; this may be due to them either taking a wider focus, such as also including their physical health, or using a broader definition of 'vulnerable migrants'.

They found no commitments on the inequalities experienced by sex workers.

They also found limited ambitions regarding peoples' contact with the criminal justice system and victims of modern slavery, while a focus 'for a minority of systems' was veterans of the armed forces and their families.

They reported that a number of systems focused on Gypsy, Roma and Traveller communities and that people with alcohol or drug dependence featured in a large proportion of strategies and plans. They also found a good degree of focus on people experiencing homelessness.

xxiii. There is a statutory duty under the Health and Social Care Act (DHSC, 2022) for ICPs to set out how assessed needs are to be met by the ICB, partner local authorities and NHSE through the Integrated Care Strategy.

Their research also presented some positive findings on inequalities and investment in prevention, stating that:

- **Systems established that they were either planning or had appointed a Senior Responsible Officer for health inequalities. Many systems named the ICS partnership boards and forums that provide strategic oversight and accountability for the work on health inequalities and prevention.**
- **Multiple systems have set intentions to reorient finances and investment into health inequalities and prevention. Several systems have established sustainable funding models and innovation funds for health inequalities. Some have set clear trajectories of investment for the next five years.**[33]

Research from the NHS Confederation looking at the first year of ICSs also presented some positive findings. It found that ICS leaders' priorities included increasing the share of resources allocated to prevention, driving improvements in population health and reducing inequalities. They identified that 'this represents a significant change in mindset among healthcare leaders away from a more medicalised NHS focus'.[18]

Alongside this, they also identified several barriers to ICSs' effectiveness. Key among these were:

Staff shortages and the lack of an equivalent long-term workforce plan for social care; a lack of funding for social care; and NHS finances, including unexpected cuts to ICB running costs and an ineffective capital regime.[18]

Given the clear desire of many system leaders to move to a preventative model, it may well be that one of the most effective things that central government can do to improve public mental health provision is to address the funding and workforce issues that occupy so much bandwidth for local decision-makers. This would free their hands to engage in the long-term, innovative prevention work that there seems to be an appetite to achieve.

Chapter 3: ICS case studies

Introduction

This chapter focuses on ICS areas in which our analysis identified both promising practice and strong strategic prioritisation of approaches and action to shift the system towards prevention and reducing health inequalities.

It does not attempt to capture every action to which the systems are committed, or to recapitulate their plans or strategies. Rather, it highlights significant public mental health-related commitments and interesting areas of practice to bring them to the attention of local and national policymakers. For the practice examples, we focus particularly on work being undertaken or planned to support the groups most at risk of mental health problems, which may be replicable in other locations.

The chapter spotlights aspects of the work of Bath and North East Somerset, Swindon and Wiltshire ICS; Dorset ICS; Frimley ICS; and West Yorkshire ICS.

Note: the **bold text** used in each case study is our own. We have used it to assist with highlighting the commitments, actions and population groups in the material presented.

Bath and North East Somerset, Swindon and Wiltshire ICS

Bath and North East Somerset, Swindon and Wiltshire (BSW) ICS covers a population of 940,000, and its Integrated Care Strategy sets out **a clear aspiration to move to a preventative approach to mental health**.

Though neither its strategy nor its five-year forward plan refers to public mental health by name, they both set out the clear importance of preventative mental health work, in particular **addressing the social determinants of mental health**.[xxiv]

Its strategy[34] sets out three objectives, the first of which is to **'focus on prevention and early intervention'**. Further, it explicitly states **an ambition to shift funding to prevention**.

They also include **a specific outcome measure: to improve ONS4 scores on personal wellbeing by 2028.**[xxv]

The strategy sets out the steps that were taken **to involve local people in its development**, and leaves open the possibility of change to the strategy based on local feedback, stating that **'residents are partners in our system – we plan with them, not do to them'**.

They present a clear implementation plan[35] to support population mental health, which includes:

- **Reinvest[ing] savings made in core mental health provision in targeted wellbeing initiatives, directing funding through our Third Sector Mental Health Alliance.**
- **Increas[ing] the number of people across our communities trained in mental health first aid.**
- **Develop[ing] targeted support offers for people who are refugees or asylum-seekers across our communities.**
- **Mak[ing] best use of social prescribing and navigation support available in primary care.**

Governance

Delivery of their plans will be **overseen by place-based mental health groups, with strategic oversight provided by the Mental Health (Thrive) Programme Board**.

Core membership of these groups includes the third sector, people with lived experience, secondary mental health services and primary care partners.[35]

Funding

Significantly, the strategy includes **a clear commitment to shift spending to prevention**: 'Making progress on achieving a shift in funding towards prevention and away from treatment is one of our key long-term priorities in BSW'.[34] It also talks specifically about holding partners to account on spending, noting that **'our ICP will monitor over time the degree to which this balance is shifting'**.

xxiv. We understand that they are currently preparing a mental health strategy, expected to be published in November 2024, which will include additional focus on public mental health specifically.

xxv. For detail on the ONS4 scores, see the ONS website: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/personalwellbeingsurveyuserguide (retrieved August 2024).

The implementation plan[35] commits partners across the ICP to 'work[ing] together to identify an accurate picture of funding and resourcing across BSW when it comes to self-care, community care and hospital care and then work[ing] towards achieving a shift in funding and resources towards the first two'. It also talks about 'reinvesting savings made in core mental health provision in targeted wellbeing initiatives', **directing funding through a third-sector mental health alliance**.

The integrated plan sets out **a clear roadmap with timings** for how they will shift to prevention, **including a timescale for developing a prevention baseline and commitment**.[35]

Inequalities

The strategy states that they **'intend to put reducing inequalities at the heart of everything we do'**.[34] The accompanying **implementation plan sets out clear governance and funding for health inequalities**, which is **overseen by the Population Health Board**; at least £2m per annum will be allocated to support this work.[35]

In the context of emotional wellbeing and mental health, it **commit[s] to addressing inequalities such as homelessness, rough sleeping and rural isolation**.[35]

BSW was one of only six ICSs whose planning documentation covers all of the population groups that the Foundation has identified as having particularly poor mental health, requiring focused public mental health action: children and young people, vulnerable families, asylum seekers and people with long-term conditions.

It is notable that it also recognises the need for **a specific focus on Gypsy, Roma and Traveller communities**, groups with particular mental health needs that are far too often underserved by state support.[36]

The strategy also sets out how it will **address inequalities across the system**, including clear plans and commitments to action:

1. **We will embed inequality as 'everybody's business' across the system.**
2. **We will develop an inequalities 'hub' within BSW Academy to host learning and development resources.**
3. **[We will have] an increased focus on children and young people.**
4. **[We will] work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are and set out clear plans on how to close the inequality gaps.**
5. **[We will] demonstrate action on inequalities that spans from system to place through joined-up strategy and planning.**[34]

The implementation plan includes **a clear roadmap**, setting out **which bodies will contribute to reducing inequalities and how, with associated timings**.[34]

Swindon's local implementation plan specifically says **'we will tailor [mental health] services for asylum seekers/refugees'**.[35] This is an important step to addressing the huge inequalities faced by people in these groups, and we hope that 'services' will include preventative public mental health programmes, and not only clinical treatment.

Its plan also includes significant detail on how it will address inequalities, including delivering workshops, a training needs analysis and other steps, many of which have already been accomplished.[35] This work is aligned with regional work in the South West to become a 'Marmot region'.[xxvi]

The implementation plan commits to appointing and training 20 staff across BSW to become **Black Maternity Matters Champions**[35] **to improve the physical and psychological safety of Black mothers**.[xxvii]

xxvi. More information about Marmot Places is available from: https://www.instituteofhealthequity.org/taking-action/marmot-places (retrieved July 2024).

xxvii. More information about the programme is available here: https://www.healthinnowest.net/our-work/transforming-services-and-systems/black-maternity-matters (retrieved July 2024).

Anchor institution role

The Integrated Care Strategy[34] sets out **a clear understanding of the need for organisations within BSW to 'play a greater role in promoting the social and economic interests of the local areas they are rooted in'.** It states that 'some organisations in BSW have already begun thinking about how they can play a bigger role as an anchor institution, helping to create jobs, forge closer links with other civic organisations and improve its carbon footprint'.

The implementation plan[35] also sets out **a specific 'enabling programme' for anchor institutions**, which is intended to 'fulfil our wider role as part of our local communities, helping to influence the health and wellbeing of our local populations'.

It sets out how hospitals and mental health trusts will take on their roles as anchor institutions by, for example, 'increas[ing the] number of local hires', 'increas[ing] community use of NHS estates' and 'increas[ing] accessible community green space'.[35]

The implementation plan provides a useful **case study on how the Great Western Hospital is taking on its role as an anchor institution**.[35]

Programmes

The Integrated Care Strategy[34] sets out plans for an **'Active Travel Social Prescribing Hub'** which will 'actively encourage improved levels of physical activity'. This aims to improve people's physical and mental health and reduce the prevalence of future health conditions. It is supported by **action to develop the transport environment to support efficient and safe travel by cycling or walking**.

In the 'local implementation plans' section,[35] the strategy states that **Wiltshire will pilot Community Conversations, starting with the neighbourhoods that have the highest level of deprivation**. This is an approach the Foundation has taken and encouraged in local systems, which is recommended in the NHS 'Working in partnership with people and communities' statutory guidance.

The ICB supports **'local places of calm'** in Swindon, Salisbury and Bath, which offer **non-clinical mental health support and signposting, in person and over the phone**.[xxviii]

xxviii. More information is available here: https://bswtogether.org.uk/yourhealth/mental-health-services (retrieved July 2024).

Dorset ICS

Dorset ICS covers the areas of Dorset Council and Bournemouth, Christchurch and Poole Council, with a population of more than 800,000.

Encouragingly, its **Integrated Care Strategy highlights 'prevention and early help' as the first of its three overall key priorities**.[37]

They **aim to 'improve the lives of 100,000 people impacted by poor mental health'**,[38] and their **JFP acknowledges the social determinants of poor mental health, noting that 'things like poverty, education and housing have a far bigger impact on health than treating sickness'**.[38]

They describe a public mental health approach, saying:

It is our responsibility to create communities where people can promote wellness and receive the support they need to thrive. To make a positive change, we need to shift the culture to create environments that enable good mental health. Early intervention and involving families are crucial in providing the right support at the right time. By doing this, we can make sure that everyone has an opportunity to maintain good mental health.[38]

They set out a five-year plan for **developing thriving communities, which includes developing their '100 conversations' community conversation model into an active network, which remains involved in the development of services**. They also have a **Voluntary and Community Sector Assembly** which will help to develop their work with communities. In the longer term, they aim to **develop community wellbeing hubs**, and aspire to local people leading and running these hubs, working in partnership with professionals.

They are also **working with the private sector**. Their 'Light on' **men's mental health campaign** 'works with more than 300 local businesses, all passionate about making a difference. A small amount of funding from health services has enabled a far greater reach and impact by trusting a key community asset – our business sector.'[xxix]

Delivery of some public mental health initiatives is included in the 'how we are going to measure progress' section of the JFP.[38] These are time-bound, but not fully SMART. For example, improving access to perinatal mental health services is an important goal, but it is unclear how many people will receive extra support.

Governance

Dorset ICS has **a Prevention, Equity and Outcomes Committee[xxx] to provide oversight and seek assurances** that NHS Dorset and partner organisations are **delivering on their commitments** to: improving health outcomes, the prevention agenda, reducing inequality and inequity, social and economic development, environmental sustainability, commissioning services which support these principles, and ensuring services are commissioned with measurable objectives and investment outcomes.

Inequalities

Dorset ICS also has **a Health Inequalities Group (HIG)** which 'brings together people from a wide range of organisations to reduce health inequalities for people of all ages. **The HIG works with the Community Conversations programme to understand what is important for people from different communities** and to find ways to tackle the barriers to being healthy'.[38]

The JFP also commits to measuring public health outcomes for older people.[38]

xxix. For details about the programme, see: https://www.lightonmh.uk/about-2 (accessed August 2024).

xxx. For more information, see the NHS Dorset governance website: https://nhsdorset.nhs.uk/about/constitution (accessed August 2024).

Children and young people

Dorset has an **Emotional Wellbeing and Mental Health Strategy for Children and Young People**, and a specific programme called 'Your mind, your say' to help children and young people with their emotional health.[38] It says: 'We will provide support to help them build resilience and cope with their feelings. We will also make sure early years and pre-schools are places where children can learn and grow while feeling good about themselves.' As part of this, they commit to putting in place **training for teachers and staff to have conversations with children and young people about their emotions**.

They also explain that 'Public Health Dorset, Active Dorset and the Youth Sport Trust are teaming up to extend an exciting programme called Healthy Movers'. This programme helps children understand why it is important to be physically fit and support their development and wellbeing so that they get a better start in life.[38]

Importantly, **the plan specifically pulls out the links between mental health and obesity, which function bi-directionally**.[38]

Adult programmes

Dorset runs a **wellbeing hub in a shopping centre in central Poole**, as part of its **'Accessing Wellbeing' programme**.[xxxi] No appointment is necessary, and the hub offers advice on:

- Mental health and emotional wellbeing
- Social connections and activities
- Bereavement and grief
- Issues such as work, money and housing.

Drop-in support is always provided in the first instance by the wellbeing coordinators, but **the hub teams work closely with other services and charities, to help link people to the right support and help**.

The hub is also used by local mental health charities, NHS mental health services, advice services and social prescribers.

The Poole hub team will 'not only provide support to visitors but **will also go out to communities where we know people experience barriers to accessing health services**. People with lived experience will also be supported to develop projects such as **peer support groups**, which will further strengthen the impact Access Wellbeing Poole will make.'[xxxi]

This new hub is part of the ICS's **wider Access Wellbeing programme**, in which organisations in Dorset work together to improve mental health and wellbeing support for the local community.

It is managed by PramaLife and Help and Care, two local charities working with **older people, carers, people with long-term conditions and people at risk of isolation**. It also involves the local council, the NHS, Legal and General, and other charities and local groups.

In addition, the **'LiveWell Dorset' programme** addresses public health issues such as weight management, smoking and alcohol, all of which have a mental health dimension. The JFP includes an aim to extend this work to **people with serious mental illness**.[38]

Several locations in Dorset run **'community front rooms'**.[38] Requiring no referral, they are described as **'welcoming, informal, safe spaces where you can discuss your problems. Staff will not offer medication or structured therapy, but rather self-management advice and support that helps you find the solutions to aid your recovery.'**[xxxii] One community front room is located at **Bournemouth University, where 'peer specialists' and mental health professionals can support and promote self-management for students**.

xxxi. See website for more information: https://ourdorset.org.uk/wellbeing/access/#poole (retrieved July 2024).

xxxii. More information is available on their website: https://dorsetyouth.com/organisations/community-front-room (retrieved August 2024).

Frimley ICS

Frimley ICS has a population of around 800,000 and covers East Berkshire, North East Hampshire, Farnham and Surrey Heath.

Its **JFP acknowledges the social determinants of poor mental health**,[39] stating that:

Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live. Understanding the holistic needs of an individual is critical to supporting people into recovery and we recognise we cannot do this in the NHS alone.

Its **plan for addressing these drivers of poor mental health** comprises the following:

- **Mov[ing] away from treating illness, and toward prevention and building the conditions for good health**
- **Support[ing] community engagement to co-produce solutions and reach communities where there are poorer outcomes to understand and address barriers to good health**
- **Promot[ing] the principles that everyone has a part to play in building and creating healthier communities, drawing on existing community assets**
- **Spreading [the] population health management approach**
- **Strengthening relationships with the VCSE and our local places**
- **Recruiting people with lived experience to be part of the solution**
- **Supporting a healthy and fulfilled workforce and building their skills and capabilities**[39]

They also set out **a similar 'whole person' approach for people with further needs**, characterised by:

- **Integrat[ing] multisector mental health expertise within Primary Care Networks to knit together support and provide easy to access help while also upskilling primary care teams.**
- **Multiagency care planning around what people need, including housing, employment, education, social isolation, and welfare support, delivered through a 'One Team' approach to community-based mental health services focused on those with SMI [severe mental illness] and complex needs.**
- **Transform[ing] complex care pathways to improve outcomes and continuity of care, e.g., eating disorder services, dual diagnosis pathways for mental health and substance misuse.**[39]

They set out specific actions on prevention and early intervention, which was rare in other plans:

Prevention and early intervention

- **Invest in co-produced and evidence-based mental health primary prevention** across Frimley's priority neighbourhoods to target inequalities e.g., skills sharing with communities, mental health literacy, anti-stigma and trauma-informed campaigns, whole school and parenting support.
- All Frimley places to have **a local suicide prevention action plan**.
- **Roll out workforce wellbeing initiatives** in partnership with Public Health and the Frimley business and enterprise sector to build more resilient communities and enhance economic growth within our geography.
- **Maximis[e] the early intervention offer, making high quality, compassionate mental health support accessible and easy to navigate when people first need it**, including accelerating the uptake of Talking Therapies and front-loading support via strategic partnerships with the VCSE.

Throughout the Integrated Care Strategy, there is a deep focus on prevention, including through the **'Living Well' programme**, which aims to achieve 'closer collaboration and partnership working with Health, local government and the Voluntary Community and Faith sector' and 'facilitate a more holistic, joined-up approach to managing the health and wellbeing of all residents'. However, this does not always include a specific focus on the prevention of mental health problems as well as physical ones, though this is sometimes implicit.

Frimley ICS has **a commitment to co-production**, saying: 'Over the last three years the 'Community Deal' ambition has focused on the principle of "doing with," not "doing to" people, encouraging people, families, and communities to take more responsibility for themselves and each other so that everyone can live in healthy and thriving communities.'[40]

Governance

This work will be undertaken and overseen by **a Mental Health Provider Collaborative**, whose **vision is to 'build emotionally healthy communities across Frimley and improve the lives of our residents living with poor mental health by using our collective expertise, resources and creativity'**.[39]

Funding

Frimley has committed to 'Invest[ing] in co-produced and evidence-based mental health primary prevention across Frimley's priority neighbourhoods to target inequalities'.[39]

In doing so, they explicitly recognise that 'It is **well-evidenced that deprivation drives health inequalities which in turn drive greater utilisation of resource-intensive treatment' and that 'a focus on the improvement of health and wellbeing outcomes in our most deprived neighbourhoods will therefore have the greatest impact on consumption of resource in the treatment of poor health**, which will free resource for reapplication in further preventative and wellbeing developments'.[40]

Inequalities

The five-year JFP recognises the **links between deprivation and race** in Frimley, including the local disparities experienced by the **Gypsy, Roma and Traveller communities** and the Nepalese community. It also notes the language barriers and risk of fuel poverty faced by local people from Black, Asian and minority ethnic communities.[39]

They set out their **commitment to addressing the inequalities facing children and young people**, including the numbers living in **poorly insulated homes** and in **households where there is domestic violence, parental substance misuse or parental mental health problems**.[39] We particularly welcome Frimley ICS's five-year multi-sector mental health workforce strategy, which commits to **developing career pathways for people with lived experience of poor mental health**.[39]

Their plan also has a strong emphasis on community involvement: they will **ensure 'all of our diverse populations are represented with the creation of an ICS inclusivity framework'**, and have an **'equity plan'** which they are co-producing and which **will promote 'cultural awareness, ally-ship and being an active bystander'**.[40]

Children and young people

In addition to addressing the inequalities experienced by children and young people, the plan explicitly talks about how **services for this group can be over-medicalised**, and **the need to empower them more, treating the person and not the condition**. It also acknowledges that 'much of the variation in how well children's lives start is caused by deprivation', saying that 'we will be investing now to create healthier communities where future generations will rely less on NHS services'.[39]

From a secondary-prevention perspective, they will be **scoping provision of a psychology support service for young people with long-term conditions**, to **reduce an escalating mental health need** within these services, setting out clearly how they will do this.[39]

A key element of their strategy is **'Starting Well'**, which aims **to address health inequalities 'through a focused approach to meeting the needs of vulnerable children who experience deprivation and poverty'**.[40]

West Yorkshire ICS

West Yorkshire ICS covers Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield, with a population of 2.4 million people living in urban and rural areas.

Given the overlap of West Yorkshire ICS with the Combined Authority area, the system appears to have a greater ability to address the determinants of poor mental health. West Yorkshire's plan and strategy are more comprehensive than we found to be usual in our review of ICS documents, which is reflected in the length and scope of this case study.

Notably, unlike most of the plans we reviewed, they set out some of the broader legal, fiscal and regulatory context and the action required from central and local governments to prevent mental health problems:

Mitigating against the structural obstacles to good health through civic action is a key to reducing health inequalities. This includes [the] use of legislation, regulation, taxation, and licensing within devolved local powers to help make healthy choices easier for people.[41]

Suicide

The strategy lists 10 major ambitions, the third of which is to 'reduce suicide rates'.[42]

This is significant, as suicide is an important public mental health issue, and achieving reductions in the numbers dying by suicide requires action to improve the mental health of the population, through reducing risk factors for poor mental health and increasing those that protect people's mental health.

Their detailed section on suicide sets out the challenges involved, including a high local rate and the difficulty of attributing responsibility for driving change.

They are adopting a 'zero suicide' approach – an initiative first developed by the Henry Ford medical system in Detroit, USA. Their Zero Suicide Guidelines list mental illness, relationship problems or losses, substance misuse, general health problems, and housing, legal, job or financial stress as factors that can contribute to suicide.[xxxiii]

Encouragingly, West Yorkshire's plan sets out **how they will measure progress**. As well as monitoring suicide rates, they will measure **the increase in the number of organisations** with specific, measurable and **evidence-based suicide prevention strategies meeting minimum standards, and the level of investment in suicide prevention across the system**.[41]

Written prior to the 2024 General Election, the plan *acknowledges 'Government policy' as well as 'the economic climate and worsening poverty, widening inequalities and discrimination, harmful content online, the gambling industry and its regulation, and the climate crisis' as drivers of suicide that are more challenging for them to address without action from central government.*

They suggest several ways to mitigate this, such as '**Invest[ing] in inclusive and preventative measures locally**, including **becoming a trauma-informed system**' and '**Ensur[ing] that suicide awareness and suicide prevention is** embedded across all organisations as **core business**'.

They have developed **two local campaigns** encouraging people to check in with their colleagues and friends, and have **a website with support resources, co-produced with people affected by suicide**. (More detail on activities to prevent suicide is provided in the West Yorkshire Suicide Prevention Strategy.[43])

xxxiii. See Henry Ford Zero Suicide Prevention Guidelines: henry-ford-health-system-zero-suicide-guidelines-2019.pdf (henryford.com) (retrieved July 2024).

Climate change

The strategy also contains much more **significant action on climate change** than most strategies we reviewed, **speaking about its mental health impacts**,[xxxiv] including those of significant weather events.[41]

They speak in detail about **the need for a system that plays a part in prevention and adapts to climate change**, saying that unchecked climate change will lead to 'significantly increased inward migration to the region from other parts of the UK facing extreme weather and flooding' and 'community collapse leading to poorer population mental health, trauma, violent crime, and possibly increased suicide rates'.[41] They set out an impressive list of **mitigating factors**, including:

- **Comfortable, efficient, and well-insulated homes safe from extreme temperatures**
- **Health and care staff who travel actively on flood-resilient green and blue routes, with local public-sector anchor organisations leading the way in their adoption of active travel**
- **Cleaner air leading to fewer respiratory, cardiac and neurodegenerative conditions**
- **Good-quality housing, and employment in a sustainable, fair local economy**
- **A regenerative, local food system that ensures all people can afford a good diet**
- **Places and systems designed to minimise, and prepare for, new infectious diseases**
- **Green social prescribing and access to green spaces**[41]

Creativity

The strategy[42] speaks at length about **the links between creativity and health, including mental health**, and seeks to extend existing work further:

As a national leader in creativity and health, we already have good examples of where we have made a real difference through using a creativity and health approach, for example our Calderdale Creativity and Health Programme working with South West Yorkshire Partnership Foundation Trust and Creative Minds. We know that expanding this learning could help us create stronger, healthier, more resilient communities through working at a population-health level. We know that it will support us in delivering targeted interventions addressing the greatest health disparities and importantly, be part of a transformation in the way health and care services look and work for everyone.

They have been working to:

- **Map and evaluate the level of health and care sector investment in arts/creativity/cultural projects across the ICS to inform future funding/commissioning opportunities and to frame future investment discussions with Arts Council England.**
- **Develop a plan [for] how the learning and successes of [...] Creativity and Health work could be scaled or replicated.[42] [Note: In Calderdale this work included an Arts on Prescription project, a form of social prescribing for which a social return on investment of between £4 and £11 has been calculated for every £1 invested.[44]]**

They have carried out interesting work in Calderdale through the Lullaby Project, **creating unique lullabies for those experiencing or at risk of post-natal depression**.[42]

They have also been working on **the development of an app, Create & Bloom**, which **aims to improve wellbeing**, and functions like **a 'creative version of Couch to 5k'**.[41]

Business and employment

West Yorkshire ICS **recognises the importance of economic growth** and the role of ICSs in contributing to this:

We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.[42]

We know that economic activity has a significant impact on health and wellbeing. Having a purpose and a living wage contribute significantly to a sense of belonging and being able to live a life well.[42]

xxxiv. This is an emerging area of research; with the Climate Cares Centre at Imperial College, London in particular carrying out important work to grow the evidence base. Information about their work is available on their website: https://www.imperial.ac.uk/climate-cares/ (accessed September 2024).

They also set out interesting work with business:

We will be working closely with the [West Yorkshire Combined Authority] to embed health and health inequalities as a consideration for any growing business or start-up [… and] seek to promote local procurement practices within the anchor institutions of each local area, including healthcare organisations.[41]

[…] we will work to address poverty and the cost-of-living across the region with a co-ordinated approach involving the public sector, third sector and the Leeds City Region Economic Partnership and local businesses […].[41]

Encouragingly, they also commit to taking a public health approach to **tackling unemployment**, including **among people with long-term health conditions**.[41]

Housing and transport

West Yorkshire ICS acknowledges **housing as a key determinant of health and 'wellbeing'** – a term that is not clearly defined but is usually considered to include elements of good mental health:

We know that having a warm safe place to call home is one of the greatest determinants of health and wellbeing and in [West Yorkshire] we have worked together to build on housing and health initiatives. The impact on health and wellbeing is determined both by the physical nature of our homes and also the emotional and psychological impact of how secure and happy we feel with our living situation.[41]

This includes **'embedding health as a consideration in all WY housing plans and interventions'**.[41]

They also specifically identify **transport as a contributor to good health and wellbeing**:

Transport is an important contributor to good health and wellbeing, through ensuring the ability to access health appointments and treatment, access good employment and to make the social connections needed. Our work with WYCA [West Yorkshire Combined Authority] will look to develop sustainable routes of transport to healthcare organisations across the region and to consider the impact on health of all future transport infrastructure and planning.[41]

Funding and anchor institution role

The Draft West Yorkshire Integrated Care System Finance Strategy 2022–27[45] sets out several commitments to support the delivery of a prevention-based approach to mental health, including:

- **Ensur[ing] that we consciously consider how […] core funding [of] all of our services can be deployed in a way that reduces health inequalities;**
- **Ensur[ing] that the health inequalities [experienced by] children and families in poverty are recognised and addressed within resource plans;**
- **Recognis[ing] that environmental sustainability can have a direct impact on inter-generational inequalities;**
- **Mov[ing] resources from treatment to prevention;**
- **Develop[ing a] procurement and contracting framework to promote local and sustainable businesses;**
- **Ensur[ing] that organisations use their role as employers and system partners to develop actions to reduce poverty and the impact on health inequalities in the communities we operate in;**
- **Maximis[ing] the role of the NHS as an anchor institution in local economies; and**
- **Commit[ting] to an increase in the proportion of resources utilised to commission services and support from the voluntary, community and social enterprise sector […].**

Inequalities

West Yorkshire is the first ICS to be awarded 'Partnership of Sanctuary' status by City of Sanctuary,[xxxv] which assessed the ICS as **providing 'safe, welcoming and accessible healthcare for refugees and asylum seekers'**. Indeed, the ICS not only acknowledges the health inequalities faced by migrants, but goes significantly further, **regarding migrants, refugees and asylum seekers as an asset to be valued**:

xxxv. For more information, see: https://www.wypartnership.co.uk/news-and-blog/news/west-yorkshire-recognised-providing-welcoming-and-accessible-healthcare-services (retrieved July 2024)

In West Yorkshire, we see our migrant, refugee and asylum seeker population as an asset to our cities, towns and communities, not a burden. Providing a safe and welcoming place of sanctuary for individuals and families should be seen as an opportunity not a threat.[42]

This approach is being embedded across the partnership through their **Improving Population Health Fellowship Programme**:

The Fellowship launched in 2021 with 33 equity fellows and will continue for a second year, expanding to include trauma, adversity and resilience, suicide prevention and climate change fellows. Our fellows are receiving training, implementing their learning in work and embedding their thinking across the Partnership and in everything we do.[42]

This is complemented by their **Health Inequalities Academy**, which 'bring[s] together partners to explore progress and share learning on tackling health inequalities'.[42] We were pleased to see their focus on **people with long-term conditions**, including **a commitment to offer them trauma-informed personalised support**,[42] and their **focus on carers**:

Working with Mental Health Trusts and VCSE organisations, we will develop a suite of resources focusing on mental wellbeing support for carers. We will engage with communities to better understand the impact of caring on mental health, with a focus on learning disabilities and ethnic minorities to improve outcomes for carers.[41]

Trauma-informed approaches

The strategy has an impressive focus on trauma, recognising that it can lead to addiction, suicide and unemployment, and acknowledging that trauma can be experienced in maternity services. To address this, West Yorkshire ICS has plans for **the Local Maternity and Neonatal System [to] become trauma-informed**, so that 'maternity services across West Yorkshire are physically and psychologically safe for all who work in them and women and families in their care'.[41] They have also produced **guidance for education settings and on trauma-informed co-production activity**.

West Yorkshire's approach to trauma-informed services[41]

By 2030 West Yorkshire is aiming to:

- **Work collaboratively across the system** with all our partners to understand our services better, understand the needs of our population and **prevent re-traumatisation**.
- Continue to support all West Yorkshire Health and Care Partnership programmes and places, **ensuring strategies and plans are trauma-informed and responsive [...]** and building the foundations for sustainability beyond 2030.
- Work towards **a culture change** across West Yorkshire that includes working together to **ensure that language** used across the system **does not further marginalise and individualise challenges** faced by those who have experienced trauma.
- Support and work with the personalisation agenda to apply a trauma-informed lens; this strengths-based approach will **support physical, psychological, and emotional safety for our population** and [...] empower people to re-establish control of their health and wellbeing, recover and live their best healthiest lives for as long as possible.
- Use evidence and embed knowledge of trauma and adversity in our work using the following **trauma-informed principles**: safety – trustworthiness – peer support collaboration – mutuality, voice, choice – empowerment and cultural humility.
- Seek to **understand and address systemic issues** such as **racism, poverty, and determinants of health to reduce inequalities, adversity, and trauma**.
- Work in partnership and co-produce with our communities in line with West Yorkshire Trauma Informed Coproduction Guidance, to **promote and support resilient communities**, wh[ich] have an important role in **preventing adversity and trauma**.

Chapter 4: Recommendations

Recommendations for Integrated Care Systems

The following recommendations focus largely, but not exclusively, on what local systems can do to improve the public's mental health.

Recommendation 1: Develop rigorous plans for public mental health.

Our analysis of ICS plans shows that many, but not all, are making real steps towards preventing mental health problems and their associated impacts, and promoting mental wellbeing and resilience.

Concerningly, it was rare to see public mental health mentioned explicitly. While systems generally grasp that many mental health problems can be prevented altogether, or prevented from worsening, and that it is important to do so, their approaches did not always seem to be underpinned by a rigorous approach to the discipline of public mental health: even where targets existed, they were not always fully quantified.

Even the best plans and strategies that we reviewed would have benefited from more clarity on their approach to preventing mental ill-health. Such a plan should include the components shown in Table 2.

These plans should also use clear language. Many of those we reviewed referred to 'wellbeing', a term that is often ill-defined and can be used in many different ways. Plans should explicitly talk about the discipline of public mental health (which certainly includes mental wellbeing and resilience), and make this central to their strategic approach and mental health-related practice. They should have explicit targets to improve the population's mental health.

Plans should be based on assessments of local need which estimate the size of unmet need for treatment of mental health conditions, prevention of associated impacts, prevention of mental health conditions, and promotion of mental wellbeing and resilience.

Table 2: Suggested key components for local plans

Domain	Component
Social determinants of mental health	Role of anchor institutions. This could include the impact of procurement and employment decisions on the determinants of mental health, as well as use of the NHS estate.
	Community wealth-building *This has been developed and shown to be effective through work in Preston.*[46]
	Local authority-led work to improve housing, reduce poverty, and develop accessible and safe green spaces for communities.
	VCSE-led work to support minoritised groups and help them to avoid poverty and other determinants of poor mental health.
Commercial determinants of poor mental health	Work to tackle health-damaging environments created by marketing and supply of junk food, smoking, alcohol, gambling and the use of 'perfect' bodies in advertising/promotion.
Support for groups most at risk	Use of programmatic work with a strong evidence base, e.g. anti-bullying programmes and perinatal mental health support.
	Work to respond to specific community needs, developed through co-production, community conversations and the mental health alliance model for people with severe mental illnesses.[xxxvi]
	Groups most at risk (e.g. people with long-term conditions and vulnerable infants, children, young people and families) should include those most frequently minoritised by the state, such as asylum seekers and refugees and people from the Gypsy, Roma and Traveller communities.
	Embedding a trauma-informed approach throughout the system.

xxxvi. For more information on this, see Centre for Mental Health. (July 2024). *More than the sum of our parts.* https://www.centreformentalhealth.org.uk/wp-content/uploads/2024/07/CentreforMH_MoreThanTheSumOfOurParts.pdf (retrieved August 2024).

Recommendation 2: Better sharing of effective practice.

While local decision-making and subsidiarity are necessary components of an efficient and responsive system, they carry with them the very significant inefficiency risk of reinventing the wheel. As public mental health work in ICSs develops, it will be critical for ICSs to share information about what is working most effectively in their areas. NHSE, DHSC, MHCLG, other central government departments, the Local Government Association, the Association of Directors of Public Health, the NHS Confederation and others should consider how they can facilitate effective sharing of good practice.

We also hope that the case studies in this report are helpful in sharing what is happening in public mental health across the country.

Recommendation 3: A stronger focus on minoritised communities.

The focus on minoritised communities in systems' plans is patchy. We were particularly concerned about the lack of focus on asylum seekers and refugees. As set out in Recommendation 1, ICSs should develop clear plans to improve the mental health of all of the minoritised communities in their areas, including the inclusion health groups.

The steps required in each local area will vary, and be dependent on the population and its needs. A first step to addressing racial inequalities would be ensuring that training in cultural competency and humility, and anti-discrimination (including anti-racism) training, is mandatory for all staff who have contact with patients, including receptionists.

We recommended in our report on the mental health of asylum seekers and refugees that systems should:

- Identify and address the drivers of suicidality among these groups. Responses will vary according to area but are likely to include culturally appropriate approaches to reducing loneliness, peer support programmes, and local measures to mitigate the poverty and financial insecurity they experience.
- Collect detailed data on suicide in their areas. Immigration status is not currently recorded or part of the 'near real-time surveillance' system. This means there is no real understanding of the extent of suicides among refugees and asylum seekers.[47]

Systems should also ensure that they are implementing the PCREF anti-racism framework and addressing inequalities affecting people with serious mental illness in line with the Core20PLUS5 programme.

Recommendations for central government and local systems

The following recommendations focus largely, but not exclusively, on central government.

Recommendation 4: Creation of a public mental health infrastructure.

We need a new public mental health infrastructure. This means the government addressing the determinants of mental health and enabling delivery of evidence-based public mental health interventions in a planned, sustained, accountable way, with clear targets and a roadmap for delivery – rather than accepting the status quo of sporadic, patchy, underfunded interventions, which amount to limited change overall for individuals and communities.

Structurally, such a planned approach to public mental health should include:

- **Cabinet responsibility at the highest level:** No. 10, or the Treasury, should have involvement, reflecting the economic and human necessity, and the social and economic benefits, of preventing mental health problems and their associated impacts and promoting mental wellbeing and resilience.
- **Re-establishment of well-resourced, arms-length public mental health expertise in central government**, following the disbanding of Public Health England and the extreme under-resourcing of OHID.
- **Restoring the public health grant** to its 2015 level with an annual £1bn boost for local councils.
- **Ambitious metrics:** These might include a drop in suicide rates, a fall in the rates of common mental illnesses and eating disorders, and an increase in wellbeing scores.

- **Specific new funding for suicide prevention;** the government's previous investment of £57m over three years ended in 2023 and has not been renewed.
- **Accountability of ICSs:** It may be that the current approach of devolving responsibility is appropriate for many physical health conditions, but public mental health is an embryonic discipline. More direction, support and measuring of shared outcomes is needed.
- **National reporting on the levels of funding allocated to public health and prevention w**ithin and beyond the NHS and local government, and on how funding is spent. The government should also set a target for all ICSs to have a clear public mental health plan in place, which should detail their spending commitments.
- **Task-sharing and capacity-building in the public sector and communities**, involving both professionals and people with lived experience, so that mental health is not seen only as an issue for the NHS.[xxxvii] NHS England should hold systems to account for implementing in full its existing statutory guidance for 'working in partnership with people and communities'.[48]
- **A cross government, longer-term mental health and wellbeing plan.** This was proposed by the previous government, but cancelled. Such a plan would encourage and support all government departments to play a part in developing a mentally healthy society, meaning that ICSs actions to promote good mental health supported, rather than undermined, by other parts of government, including the welfare and asylum systems.

We also support the recommendation of the Royal College of Psychiatrists for **a national-level mental health needs assessment**. This should include determining the level of need in the population for treatment of mental health conditions, prevention of associated impacts, prevention of mental health conditions, and promotion of mental wellbeing and resilience.

Such an assessment then informs decisions regarding the most suitable and implementable options to address the gap, as well as agreement about acceptable levels of coverage of different public mental health interventions and how this would be monitored.[xxxviii,49]

Additionally, the UK Government must address the wider social, economic and commercial determinants of mental health, by:

- Giving children the best start by prioritising the elimination of child poverty, with a clear, timebound target for this to be achieved.
- Improving people's security by ensuring everyone can afford a healthy life with an adequate income and a decent home. This should include reforming sick pay legislation, introducing an Essentials Guarantee in Universal Credit to at least cover the essentials of food, and providing more homes for social rent.[xxxix]
- Creating and enabling physically and mentally healthier living environments by better incentivising active travel and public transport; ensuring everyone can access safe, good-quality green space; and improving protection from commercially driven risks to good mental health, including body-image-related harms, smoking, alcohol and gambling.[50]

Recommendation 5: More funding for prevention.

In addition to the systemic change needed to create a public mental health infrastructure, protected, long-term funding is required.

It is unreasonable to expect the change that is needed to occur within the existing financial envelope, particularly given the cut to operating costs that ICSs have experienced.

As set out above, the government should introduce a full national needs assessment of the implementation gap in public mental health, and ensure funding is in place to deliver the work needed to address this. Part of this will involve the restoration of the public health grant to at least the 2015 level.

xxxvii. 'Task sharing' approaches have been shown to be effective in other jurisdictions. For an overview of how they can work and what steps might be needed for them to be effective, see: Stevens et al. (2020). *Helpers in Plain Sight: A Guide to Implementing Mental Health Task Sharing in Community-Based Organizations.* RAND Corporation. Available at: https://www.rand.org/pubs/tools/TL317.html (retrieved July 2024).

xxxix. The Essentials Guarantee campaign is led by the Joseph Rowntree Foundation and the Trussell Trust.

The government must also provide that adequate funding is available to local authorities for suicide prevention; at a minimum, this would involve the renewal of the cancelled £57m three-year funding for suicide prevention.

NHSE and DHSC need more focus on the long term, to avoid priorities such as waiting lists and ambulances from derailing a move towards prevention.[xl] This needs to be reflected in the way ICSs are funded. As the Hewitt Review (2023) recommends, this requires a shift in resources. We support the review's proposal that **the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1 per cent over the next five years**. This needs national funding support. Should sufficient funding be made available for ICSs to meaningfully invest in preventative public mental health work, we would advocate for an equivalent of the Mental Health Investment Standard: **a 'Public Mental Health Investment Standard'**.

We also support the Hewitt Review's recommendation that there must be greater adoption of **recurrent, multi-year financial settlements, to aid longer-term planning and investment**.[7]

In general, the state carries out too little work on prevention, and this is in part because funding is often in competition with other types of expenditure. We are supportive of Demos' call for a new category within Departmental Expenditure Limits: **Preventative Departmental Expenditure Limits**. They argue that this would 'classify and ring fence preventative investment, injecting long-termism into public spending'.[51] This has the potential to rebalance the way we consider expenditure as a country and allow us to take longer-term decisions.

Currently, around 3 per cent of local authorities' public health budgets are used for specific public mental health interventions. While some physical health interventions will also support mental health, it is clear that this spending is very far from parity, and local authorities should look to increase this proportion of spend.[26]

Recommendation 6: Better collaborative working between the centre and ICSs.

The Foundation supports the NHS Confederation's call for more co-production of national policies and guidance, with ICSs and NHSE working together to develop this.[18]

Such an approach should recognise the deep impact of inequality on mental health, and prioritise action aimed at minoritised communities, people living in poverty and others – for example, the 'inclusion health groups', who have previously not had their needs well met.[xli] This must include asylum seekers and refugees. To achieve this, it must be fully inclusive, involving the VCSE, other sectors, communities and people with lived experience.

Recommendation 7: Mental health and wellbeing policy and spending impact assessment.

The UK government must fulfil the commitment made under the previous government's interim Major Conditions Strategy report (for England) to develop a Mental Health and Wellbeing Impact Assessment Tool to support policymakers in considering the mental health and wellbeing effects of their policies.[52]

This tool must be widely adopted. The UK government should ensure that all government departments apply it to the development of new policies, as well as areas of government policy that have historically damaged, rather than supported, particular groups' mental health, including the asylum and welfare systems. It should also encourage its uptake (with any necessary adaptations)

xl. 'A key theme that emerged in NHS Confederation research; see: NHS Confederation. (2023). *The state of integrated care systems 2022/23: Riding the storm.* https://www.nhsconfed.org/publications/state-integrated-care-systems-202223 (retrieved June 2024).

xli. Inclusion health groups are described by NHS England as 'people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.' See website: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups (retrieved July 2024).

by local health systems. Such a tool can be used to make decisions relating to addressing the commercial determinants of mental health, including the gambling, food and smoking sectors.

We also support the NHS Confederation's recommendation that the health implications of spending decisions be introduced as new criteria in the Treasury's Green Book and accompanying guidance. This should include the mental health implications of decisions.[22]

Recommendation 8: An increased focus on children and young people.

Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24.[53] Well-evidenced prevention and early intervention programmes can prevent a range of adverse outcomes, including having mental health problems as an adult. DHSC, OHID and NHSE should work with local systems to ensure widespread availability of these cost-effective programmes to improve infants', children's and young people's mental health. This should include digital interventions; children and young people need the option to access effective support in ways that work for them, at any time.

Every parent and carer should have access to effective support, including evidence-based parenting programmes,[54.55] and every school and college should be a mentally healthy place for children and young people. This should include provision of evidence-based mental health literacy programmes to give children and young people the skills and confidence to understand and manage their emotions and mental health.

We also endorse the recommendations of the Children and Young People's Health Policy Influencing Group that DHSC should provide clear guidance to ICSs on addressing the needs of babies, children and young people with major and long-term conditions in their updated Integrated Care Strategies and ICB JFPs.[56]

Recommendation 9: A cross-departmental inequalities strategy.

The government should develop a cross-departmental strategy to reduce health inequalities, focusing on reducing inequalities in the population that cause people to become unwell in the first place, in line with the policy calls of the Inequalities in Health Alliance, convened by the Royal College of Physicians and supported by 250 members.[xlii] It should also include prevention of a range of inequalities that can arise from having a mental health problem, and seek to develop a shared understanding of inequalities and their effects.

Recommendation 10: Action to address wider systemic issues.

The NHS Confederation research has shown that system leaders have a strong desire to move towards greater integration and a preventative model, but also that systemic issues around funding, social care delivery, workforce and capital are holding them back.[18]

Clearly, it is not reasonable to expect local systems to excel at public mental health delivery when they are struggling to deliver on other core responsibilities. To free up system leaders to focus on preventative mental health work, the government must address these wider challenges facing the NHS and local authorities.

xlii. Information about the work of this alliance is available on the website of the Royal College of Physicians: https://www.rcp.ac.uk/policy-and-campaigns/our-public-health-alliances/inequalities-in-health-alliance (retrieved July 2024).

Recommendations for further research

As a country, we do not currently understand what action is taking place with regard to public mental health, the level of need, or the best ways to address that need. The government should prioritise the following work.

Scale and sustainability of interventions:

- Conduct research to identify and implement well-evidenced public mental health interventions that can be delivered at scale and sustained over time.[xliii]
- Develop frameworks and guidelines to support the scaling of successful interventions across different regions and populations.

Resource allocation:

- Undertake a detailed analysis of the total and proportional resources allocated to public mental health and prevention within the broader mental health budget.

Evaluation and dissemination:

- Commission evaluations of promising public mental health initiatives to assess their effectiveness and scalability.
- Establish mechanisms for the dissemination of evaluation findings to local systems, ensuring that best practices are shared and adopted widely.

Suicide surveillance:

- Expand real-time suicide surveillance systems to include data on asylum status, enabling a more accurate understanding of suicide rates among asylum seekers.
- Use these data to inform the development of targeted public mental health interventions for asylum seekers and other vulnerable populations.

Addressing health inequalities:

- Conduct research to understand the extent to which ICSs are addressing the mental health needs of communities experiencing significant health inequalities, beyond those covered in this report.
- Understand the extent to which ICSs are addressing the mental health needs of communities which experience significant health inequalities beyond those we have looked at in this report. These groups include: homeless people, members of the Gypsy, Roma and Traveller communities, and members of the LGBTQ+ communities.

This report calls for greater accountability on public mental health, alongside, crucially, the funding to allow ICSs to make real steps to support their public's mental health. Such an accountability mechanism would require central government to build on this report to develop a thorough understanding of how well ICS plans and strategies match action, and develop detailed criteria and indicators so that ICSs can be measured on public mental health performance.

xliii. This is one of the aims of the RCPsych Public Mental Health Implementation Centre. Details are available on their website: https://www.rcpsych.ac.uk/improving-care/public-mental-health-implementation-centre/aims-and-objectives (retrieved August 2024).

Appendix: Criteria for evaluating strategies and plans

This research used the following criteria to assess ICSs. The evaluation focused on documents published by each system, including the Integrated Care Strategy and the JFP. These documents were analysed to determine how well they address various aspects of public mental health and prevention strategies. The criteria used in this assessment were as follows:

Public mental health

Mention of 'public mental health': Whether the concept of public mental health is explicitly mentioned or whether descriptions of public mental health activity are articulated less directly within the strategy or plan.

Mention of public mental health interventions: Whether the strategy specifically mentions any interventions aimed at improving public mental health.

Details on public mental health interventions: Specifics on any public mental health interventions mentioned in the strategy, including:

Focus on areas identified in the economics of prevention report: Whether the strategy focuses on areas highlighted in our report *The economic case for investing in the prevention of mental health conditions in the UK report*, which outlines cost-effective prevention strategies.

Inclusion of the five ingredients: Whether the strategy includes any of the five essential components critical for effective public health interventions we have identified. These are:

- Provide information/education about mental health
- Develop skills/strategies to support people to feel more empowered/in control
- Increase relational/social contact
- Involve an additional activity with an evidence base around positive effect on mental health
- Have a systemic focus which places individual, family or group mental health in a broader context?

Commitment to improving population mental health/ wellbeing: A clear commitment within the strategy to enhance the overall mental health and wellbeing of the population.

Board representation with experience in prevention/ public mental health: The presence of individuals on the Integrated Care Board with experience in prevention or public mental health.

Prevention

Importance of primary prevention: The emphasis on primary prevention efforts, which involve reducing the incidence of mental health problems through universal measures or by targeting high-risk groups.

Secondary prevention: The inclusion of secondary-prevention measures, such as detecting early stages of mental ill-health and intervening before mental illnesses develop.

Tertiary prevention: The focus on tertiary prevention – that is, interventions for people who already have mental health problems which promote mental wellbeing and recovery and minimise disability.

Addressing social determinants

Understanding of social determinants and health inequalities: Recognition of the impact that social determinants (e.g. poverty, education, housing) have on mental health and the creation of health inequalities.

Understanding of risk factors for poor mental health: The strategy's understanding of the risk factors for poor mental health, such as poverty, unemployment and social isolation, which public mental health approaches seek to address.

Support for at-risk populations: The extent to which the strategy acknowledges and addresses the needs of at-risk populations, including various vulnerable groups.

Community engagement

Community-based, non-clinical approaches: The use of community-based, non-clinical approaches, such as social or environmental interventions.

VCSE involvement in reaching at-risk populations: The inclusion of voluntary, community, and social enterprise (VCSE) organisations in reaching and supporting at-risk populations.

Additional criteria

Internal rating (Good, OK, Poor): An overall internal rating of the strategy or plan, categorised as Good, OK or Poor, based on the assessment.

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