

**OPSN REPORT**

Getting the message on mental health:  
From public data to public information

# Exploring how available NHS data can be used to show the inequality gap in mental healthcare

A report by the RSA Open Public Services Network  
**November 2015**



# The expert panel

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<b>Alex Kafetz</b>	COO, ZPB and Member of the National Information Board
<b>Professor Simon de Lusignan</b>	Head of Department of Health Care Management and Policy, University of Surrey
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<b>Roger Taylor</b>	Chair, OPSN
<b>James Thompson</b>	Senior Research Analyst, The King's Fund
<b>Suki Westmore</b>	Engagement Manager, Mind
<b>Annie Whelan</b>	Development and Implementation Lead, Mental Health Forum and Member of the National Information Board

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Members of the panel attended in a personal capacity and this report does not necessarily represent the views of their organisations.

The panel would also like to thank: Paul Farmer from Mind for his advice and support through the process; David Mullet for his data analysis; Sophie Jenkins from ZPB Associates and Tom Harrison from the RSA for their research and report writing; and the team at DTC for designing and developing the website and this report. We also thank David Shiers MBChB, MRCCP and former general practitioner, for advice about QOF data. And finally we thank Professor Robert Stewart, Professor of Psychiatric Epidemiology and Clinical Informatics at King's College London, for advising and giving us access to the mortality aggregates.

This project was kindly funded by the Cabinet Office Release of Data Fund<sup>1</sup>.

The Quality and Outcomes Framework (QOF) data and local authority data used in this report is from 2013/14 and was extracted from Public Health England's Fingertips website<sup>2</sup> in May 2015. It was the best available data at the time. Data on mortality rates were extracted in October 2015.

<sup>1</sup> <https://data.gov.uk/blog/release-data-fund-update>

<sup>2</sup> <http://fingertips.phe.org.uk/>

# Why this project?



Charlotte Alldritt



Roger Taylor

Poor mental health is one of the biggest challenges facing our society today. In the UK, one in four adults experience mental health problems in their lifetime, with one in six experiencing a diagnosable mental health problem in any one year<sup>3</sup>. It is now clear that the social and financial costs of poor mental health are substantial, with consequences for the economy, physical health outcomes and wider social problems, such as homelessness, crime and drug abuse. The cost to the economy in England is an estimated £105 billion per year<sup>4</sup>.

**Despite the size of this cost and the degree to which depression and anxiety is known to be widespread, mental health has historically not been held in the same regard as the nation's physical health needs. Mental health has received less funding and policy attention than other disease areas<sup>5</sup>.**

There has been a push to use better information to raise awareness of health issues both among the public and among professionals. We expect that data will be available about the services we use. The Department of Health has been at the forefront of providing access and accessibility to NHS data to support patients' choice and control over their care. Websites such as [NHS Choices](#) and [My NHS](#) provide people with accessible information about their local health services, empowering them to make decisions about where and how they receive their care. However, information about mental health services is underprovided, poorly presented and typically not useful to service users.

<sup>3</sup> Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. (2001) Psychiatric Morbidity Among Adults Living in Private Households, 2000. London: The Stationary Office

<sup>4</sup> Department of Health and HM Government, No health without mental health: A cross-Governmental Mental Health Outcomes Strategy for People of All Ages, 2011

<sup>5</sup> The Mental Health Policy Group – General Election 2015, A Manifesto for Better Mental Health, <http://www.mentalhealth.org.uk/content/assets/PDF/publications/manifesto-better-mental-health-manifesto.pdf>

Examining first person narratives on sites such as Big White Wall and Twitter suggests confusion and frustration with the lack of available data. It is this lack of accessible data about mental health services that has driven OPSN to pursue this project. OPSN believes that transparency of data – including the degree to which it can be readily understood by the public – is essential to drive improvement in services, ensure accountability and enhance patient choice.

In recent years, mental health has risen on the political agenda. In 2011 the coalition government published No Health Without Mental Health, a cross-departmental strategy document, which sought to mainstream mental health in England and establish parity of esteem between mental and physical health.

This symbolised an end to viewing mental and physical health in a binary fashion, instead recognising the holistic nature of mental health and its interdependent relationship with physical health. One significant aspect of this strategy for our research is its commitment to ensure “more people with mental health problems will have good physical health”.

However, despite the positive intentions outlined in the 2011 coalition strategy, it is still widely accepted that people with mental health problems will suffer because of unmet health needs and that more will die younger. People with serious mental illness (SMI) have higher mortality and morbidity rates and die on average 10 to 20 years younger than the general population<sup>6</sup>.

## The brief

**This project, funded by the Cabinet Office Public Sector Transparency Board, set out to explore how far public data about mental health services could be turned into useful public information for people using those services, their families and local communities.**

We have explored the extent to which we can take openly available data and re-analyse it to try to answer key questions about how well people with mental illness are being cared for in primary care. Inevitably, more or better quality data is required (we mention specifics in our recommendations), but this project’s specific challenge was to explore the extent to which we could re-use and re-present available data in a way that helps people understand the services and health risks to themselves and those in their family or community.

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<sup>6</sup> Department of Health and HM Government, No health without mental health: A cross-Governmental Mental Health Outcomes Strategy for People of All Ages, 2011

# Key project outcomes

- A website was created using some relatively simple statistical techniques to aggregate data and identify significant differences in mortality rates among people with SMI and the degree to which local primary care services were failing to provide equally effective care: [thersa.org/mentalhealth](https://thersa.org/mentalhealth)
- People living with serious mental illness found this information useful and were interested in seeing it presented in a simple website along with information about what action they could take.
- In focus groups, users of mental health services suggested many ideas about information that people would additionally like. The full report of the groups is here: [thersa.org/mindfocusreport](https://thersa.org/mindfocusreport)
- Using similar analytical approaches, data sets were created that highlighted the success of different areas to support people back into employment and housing or to give people with SMI greater control over their lives.
- Further analyses were done to indicate relative quality of psychological therapies in different areas.
- These data sets have been published as open data and are reported more fully below.

# Key project findings

The available data for understanding mental health services is extremely limited. A number of specific issues were raised.

→ **Lack of public information.** Just as mental health services in general are overlooked in comparison to physical health, the same is true in terms of public information. Public information about mental health services falls far short of public information about services for physical health.

→ **Lack of data.** Most of the available data is focussed on secondary care services. The richest information is about hospital and community care services, followed by information on the NHS psychology service, which is termed the Improved Access to Psychological Therapies (IAPT) services. There is very little information on primary care services beyond rates of diagnosis and prescription of antidepressants, despite the fact that is where 80-90 per cent of all those with mental ill health present for treatment<sup>7</sup>.

For eight years, patients have been able to compare local hospitals on NHS Choices using metrics such as CQC ratings, staff recommendations, infection control and cleanliness, mortality rates and food choice. These measures are important when faced with high acuity, inpatient care. However, mental health issues rarely manifest themselves in a quantifiable, physically comparable way. Standard hospital measures do not even begin to scratch the surface of mental healthcare in this country.

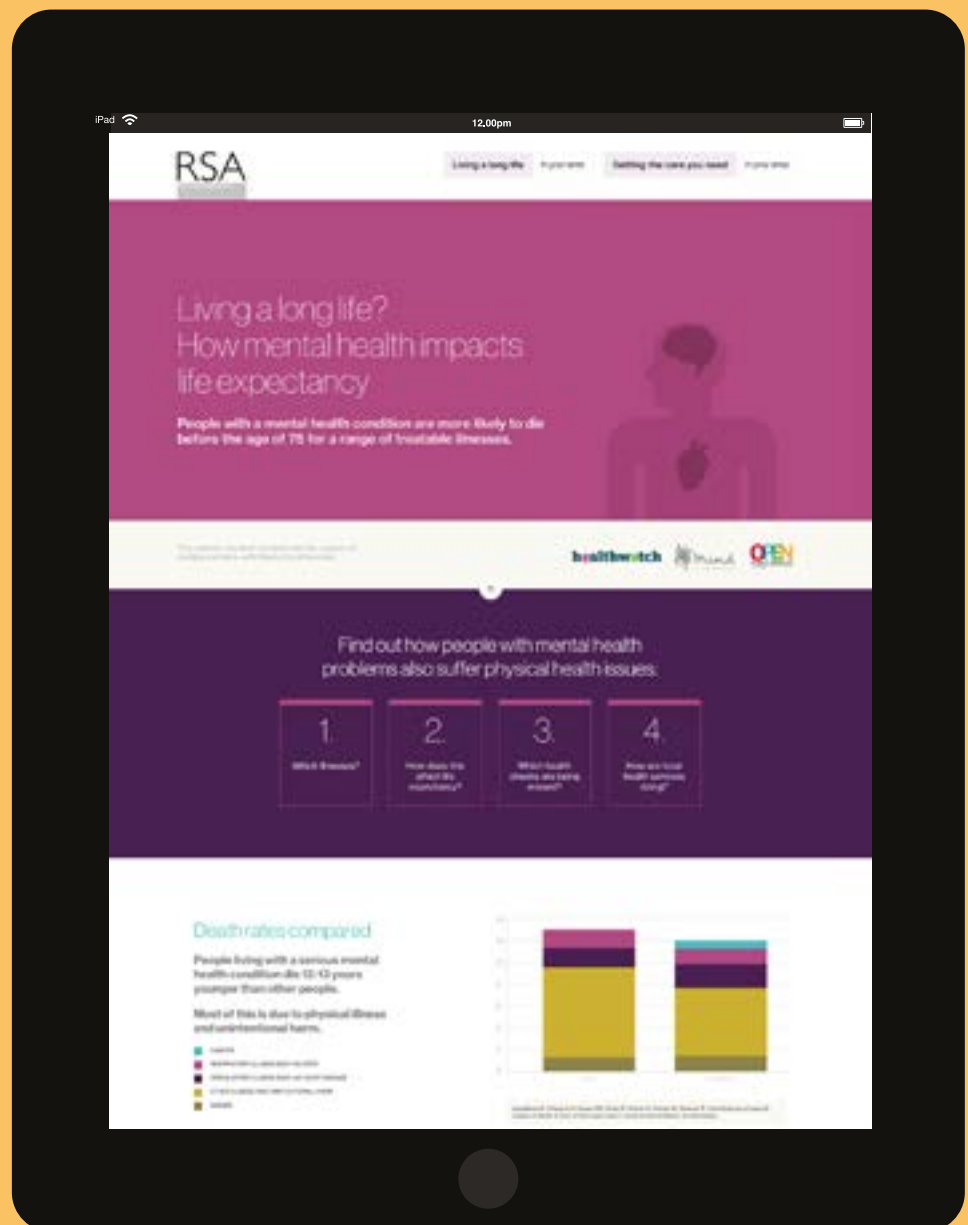
<sup>7</sup>The Fundamental Facts: the latest facts and figures on mental health, The Mental Health Foundation, 2007

- **Access to data is extremely restricted.** The restriction preventing responsible organisations from accessing linked hospital episode statistics (HES) and mental health minimum dataset (MHMD) was identified as a key issue for researchers to understand the care given to people with mental health conditions. Mental health data is treated as more confidential than data about people's physical health. There is a risk that this attitude helps to perpetuate the stigma attached to mental health and hides the costly interaction between mental health and use of hospital resources.
- **Access to data is slow.** Even where organisations are in theory allowed access to data, receiving it remains problematic. The panel reported that some organisations have been waiting more than a year for the Health and Social Care Information Centre (HSCIC) to approve their data request.
- **Reduction in available information.** Some of the data used to create The Living a long life? website<sup>8</sup> will not be available as the little data that is available currently is being scaled back as a result of changes to GP pay-for-performance (P4P) remuneration, the Quality and Outcomes Framework (QOF). These changes tilt the P4P incentives towards physical health over mental health.

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<sup>8</sup> <https://www.thersa.org/mentalhealth>

Want to access  
our site? Visit  
[thersa.org/mentalhealth](https://thersa.org/mentalhealth)



Download the data: [thersa.org/mentalhealth-data](https://thersa.org/mentalhealth-data)



# Why is this important?

In its 2014 paper, Closing the gap: priorities for essential change in mental health, the Department of Health said:

**“We need a truer, more up-to-date and more detailed picture of mental health and wellbeing nationally and in each area.”**

The OPSN is tackling this head-on with the launch of our new platform, ‘Living a long life? How mental health impacts life expectancy’, in association with Mind. We believe that open access to information is vital for communities to self-organise, as people empowered with the right information can engage more effectively with their health services, and help to narrow the life expectancy gap between those with serious mental illnesses and those without.

With funding from the Cabinet Office Release of Data Fund and based within the Royal Society of Arts (RSA), OPSN has mapped mental health inequalities across the UK and is working with statutory authorities to improve health outcomes by improving accountability at the community level and ensuring civic participation is realised.

We have teamed up with Healthwatch in order to forward this participation. By linking up with local Healthwatch networks we hope that people will be inspired to get involved in shaping local services. Through open access to information and partnerships with organisations such as Healthwatch we want to improve civic engagement so we can begin to close the gap together.

# Our approach

As a programme based at the RSA, OPSN aims to improve the accessibility and usefulness of public information about public services. To do this, we test new ways to present information and provide independent assessment of government and public services performance data.

This is our first project examining health, specifically mental health services in the UK. The specific objectives of the project were to:

- Improve the accessibility of data about mental health services for the public and service users;
- Present data in ways that provide insight by clearly identifying the availability and quality of services within local areas;
- Publish these as a new dataset under an open data license so that researchers can use it to better understand the care of mental health services; and
- Present this data in ways that improves accountability and engages the public and service users through better understanding of the services available to them.

As well as analysis of available data (providing four new composite measures of comparable outcomes for Clinical Commissioning Groups and local authorities in England), OPSN has sought to communicate mental health data in an accessible web tool [www.thersa.org/mentalhealth](http://www.thersa.org/mentalhealth). This tool is designed to enable mental health service users to understand data about how the physical health needs of people with serious medical illness (SMI) are being met at a primary care level. This report accompanies the web tool, providing an explanation of our research process and approach.

Data analysis was undertaken by Professor Simon Jones, New York University, and David Mullett, University of Surrey. They produced composite indicators using OECD specification and best practice<sup>9</sup>. While composite indicators have a degree of controversy often described as 'too simplistic' or masking underlying problems, we believe this is digestible for members of the public to quickly and easily understand how their local area is looking after their needs. Please see our full methodology at [www.thersa.org/mentalhealth-methodology](http://www.thersa.org/mentalhealth-methodology)

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<sup>9</sup> <http://www.oecd.org/els/soc/handbookonconstructingcompositeindicatorsmethodologyanduserguide.htm>

# Our process

The OPSN convened an expert group with a variety of expertise in the field of mental health to provide strategic oversight and guidance on how to improve access and accessibility to mental health data, aimed specifically at mental health service users. The expert reference group met three times between February and October 2015. These meetings determined the scope, direction and methodology of the project by enabling the members to discuss the currently available information around mental health services and the shortcomings of the available dataset.

The panel reviewed existing mental health frameworks in its first meeting, such as My NHS and NHS Choices, as well as currently available data sources, to explore what questions the report should address.

The group considered the shortcomings of the available datasets and the extent to which these might limit our analysis of our key questions. Large inadequacies in the current coding system used for mental health were identified (see list on page 6).

The OPSN expert panel examined the existing data and reviewed more than 200 metrics, distilling them to a number of indicators for our analysis. Through discussions with the panel it became apparent that we could add most value by reanalysing information about the primary care given to people with serious mental health conditions. This in turn fed in to our four composite measures of mental healthcare identified by the panel and which guided the research:

1. How well is my GP looking after my physical health needs?
2. What is the likelihood of getting access to the right psychological therapies, and what is the outcome if I do?
3. Am I more or less likely than average to be prescribed anti-depressants?
4. How well am I supported to live well with my condition?

The driving principle of the project – guiding our analysis, web development and engagement with the expert panel – was to ensure that the data we were to communicate would have to be useful to service users. To this end we commissioned Mind to run two focus groups, one in London and one in Birmingham, on service user testing of the website. The purpose of this was to present service users with the opportunity to understand the data that is publically available and provide feedback as to how this information should be presented with most utility.

The feedback from these two sessions fed into the website design in terms of both format and content and resulted in links to advice on key physical risks and steps to take to get appropriate support. In the spirit of transparency we have published the details of these focus groups on the RSA website [www.thersa.org/mindfocusreport](http://www.thersa.org/mindfocusreport).

The project budget (£70,000) did not allow us to develop four different presentations of data for service users. We therefore concentrated our efforts on the issue that prompted most interest in the discussion groups and where we were able to add most value.

'Living a long life? How mental health impacts life expectancy' is a web-based tool designed to raise awareness of the impact of mental health on physical health and to help people to understand how well GPs are looking after the physical health needs of people with serious mental health concerns.

It is important to focus on mental health beyond the hospital setting, as people with SMI receive 25 per cent of their treatment from primary care services and have on average 13 to 14 GP consultations annually<sup>10</sup>. Primary care is vital in helping people with mental health problems to improve their physical health.

Data for all four questions looked at has been published as open data and is described in more detail in the following section.

Every CCG has been given an OPSN banding of 'low', 'as expected' or 'high' based on our analysis of the first three questions. The fourth question uses data at the level of local authority (LA) to create an index of how well people in each LA area are helped with employment, housing and greater control over their own care.

It is important that we emphasise that a banding of 'high' is only relative for that particular indicator; it can still reflect an unacceptable disparity in outcomes in comparison to the rest of the population. The metrics used to measure this and the other composites are discussed in the following section.

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<sup>10</sup> The Fundamental Facts: the latest facts and figures on mental health, The Mental Health Foundation, 2007

# What the data tells us



# 1. Living a long life?

## The impact of mental health on physical health

The [Living a long life?](#) website includes information about the extent to which people living with a mental health condition are likely to suffer higher rates of physical illness and die prematurely as a result. To understand the difference in physical health outcomes between the SMI and general populations, OPSN compared every Clinical Commissioning Group (CCG) in the country for two key indicators for the rate of risk to the SMI population:

1. Comparison of mortality rates for the general population and the SMI population at CCG level. Our analysis was limited to adults under 75 years in order to reflect the upper age threshold in the definition of premature mortality.
2. Comparison of how well GPs are referring people with SMI for vital physical health tests with the rest of the eligible patient population. Here we calculated a series of OPSN bandings for every CCG based on a summary score of six QOF physical health check indicators. In addition, we compared whether GPs were sending them for three essential health checks, which included blood pressure, cervical screening and heart disease, as these were recorded in a way that are directly comparable for mental health.

The data are explained on the following pages.

# Mortality data

People with serious mental health problems are at an increased risk of adverse physical health outcomes than the general population:

- It is estimated that one in three of the 100,000 people who die prematurely each year in England have a mental illness<sup>11</sup>.
- In 2013 mortality among adult mental health service users in England was 4,008 per 100,000 (83,390 deaths)<sup>12</sup>.
- The SMI patient population accounts for five per cent of the total population, but 18 per cent of the total deaths<sup>13</sup>.

Although suicide does count for a significant proportion of these deaths, an estimated 60-70 per cent of excess mortality among people with mental illness is due to physical ill health<sup>14</sup>. Physical and mental illness often coexist in an interdependent relationship, each having a great impact on the other: 30 per cent of people with a long-term condition have a mental health problem and 46 per cent of people with a mental health problem have a long-term condition<sup>15</sup>.

People with mental health disorders also have higher rates of respiratory, cardiovascular and infectious diseases, obesity, abnormal lipid levels and diabetes<sup>16</sup>. They are nearly four times more likely than the general population to die from diseases of the respiratory system, more than four times more likely to die from diseases of the digestive system, and twice as likely to die from diseases of the circulatory system<sup>17</sup>.

The website quotes figures highlighting the degree to which people with SMI suffer poorer physical health, including:

1. Research by King's College London (forthcoming) calculates the life expectancy gap between people with SMI in South-East London and the rest of the population. Its analysis also identifies how different causes contribute to this gap.

For the purposes of this website, analysing the data in this way provides information in a much easier to understand format than the more usual methods of calculating SMRs or death rates.

<sup>11</sup> Rethink Mental Illness, Lethal discrimination: Why people with mental illness are dying needlessly and what needs to change, 2013.

<sup>12</sup> HSCIC Mental Health Minimum Data Set, <http://www.hscic.gov.uk/article/4865/Mental-Health-Minimum-Data-Set-MHMDS>

<sup>13</sup> Shukla H and Watson S (2013) A Tale of Two Populations, 2013 (Based on ONS Data)

<sup>14</sup> BMA (2014), Recognising the importance of physical health in mental health and intellectual disability: achieving parity of outcomes, JAMA Psychiatry, 72(4):334-341

<sup>15</sup> Naylor C, Parsonage M, McDaid D et al (2012) Long-term conditions and mental health. The cost of co-morbidities. London: King's Fund, Centre for Mental Health.

<sup>16</sup> De hert M, dekker JM, Wood d et al (2009) Cardiovascular disease and diabetes in people with severe mental illness. Position statement from the European Psychiatric Association. European Psychiatry.

<sup>17</sup> Holt, RIG (2011) PCCJ Practice Review. Cardiovascular disease and diabetes in people with severe mental illness: causes, consequences and pragmatic management.

2. Standardised mortality ratios by cause of death among people with SMI or schizophrenia. The rates are quoted from a range of studies compiled by the Royal College of Physicians and the Royal College of Psychiatrists (2010), called No health without public mental health: The case for action. Two systematic reviews from 2007 and 2015 of physical health in people with schizophrenia are also used:
  - a) Saha S, Chant D, McGrath JA. Systematic Review of Mortality in Schizophrenia: Is the Differential Mortality Gap Worsening Over Time? *Arch Gen Psychiatry*, 2007; 64(10):1123-1131.
  - b) Mark Olfson, MD, MPH, Tobias Gerhard, PhD, Cecilia Huang, PhD, Stephen Crystal, PhD, T. Scott Stroup, MD, MPH. Premature Mortality Among Adults With Schizophrenia in the United States. *JAMA Psychiatry*. Published online 28 October 2015. 3.
3. The final source of data is UK public data about mortality rates below the age of 75. Two sources are used: for the general population we have data on years of life lost from causes amenable to healthcare; for people with SMI we have a standardised all cause under-75 mortality rate compared with the rest of the country. Both sets of data are at CCG level. Again, we have expressed these figures in terms of how much more likely a particular group of people is to die prematurely (before 75). We compare the relative likelihood for the general population within each CCG (using the YLL) measure and the rate for people with SMI within each CCG (using the SMR).

The latter figure is also compared to the elevated risk of death for people with SMI across the whole country. This illustrates that people with SMI are at greater risk wherever they live. We have also identified those areas where the CCG mortality rate within an area is significantly better or worse than for people with SMI nationally.

## Gaps in the available data:

We would have preferred to express all the information at CCG level in terms of years of life lost rather than the degree to which people were more likely to die prematurely. However, data was not available in this form.

We would have preferred to have an equivalent indicator for people with SMI looking at years of life lost due to causes amenable to healthcare.

We did not include data on smoking cessation because of concerns about validity. While there was comparable data for GPs providing smoking cessation advice, more people with SMI were recorded as having been referred for advice compared with the whole population. Given that we know smoking prevalence is still much higher for people with SMI<sup>18</sup>, the panel and OPSN team agreed that this failed a 'face-validity' test and we decided to omit this indicator from our composite. This could also reflect the fact that current models of cessation advice are less effective for SMI groups.

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<sup>18</sup> Action on Smoking and Health, Fact Sheet, 2013, [http://ash.org.uk/files/documents/ASH\\_120.pdf](http://ash.org.uk/files/documents/ASH_120.pdf)



The indicators for the whole population and people with SMI were not exactly the same. For example, for cholesterol the whole population measure is: The percentage of patients with coronary heart disease whose last measured total cholesterol is 5 mmol/l or less. Whereas for people with SMI the metric is: Patients with SMI with cholesterol check: per cent with record in preceding 15 months. However, the OPSN and the expert panel believed that these measures were close enough for a comparison to be valid.

Although there has been some research around the variations in emergency admissions and other secondary care episodes for people with SMI, as far as we know this is the first time comparisons of mortality rates for the SMI population have been drawn at CCG level, meaning our research provides the first look at how these differences are reflected in primary care.

The data conveys a complex picture, with several CCGs exhibiting lower than average mortality rates for the general population while concealing much higher mortality rates for people with SMI. For example:

- NHS Bath and North East Somerset CCG, where mortality rates are 37 per cent below average for the whole population but 307 per cent above average (and statistically significantly so) for people with SMI.
- NHS Wokingham CCG, where mortality rates are 29 per cent below average for the whole population but 305 per cent above average (and statistically significantly so) for people with SMI.
- NHS Kingston CCG, where mortality rates are 28 per cent below average for the whole population but 340 per cent above average (and statistically significantly so) for people with SMI.

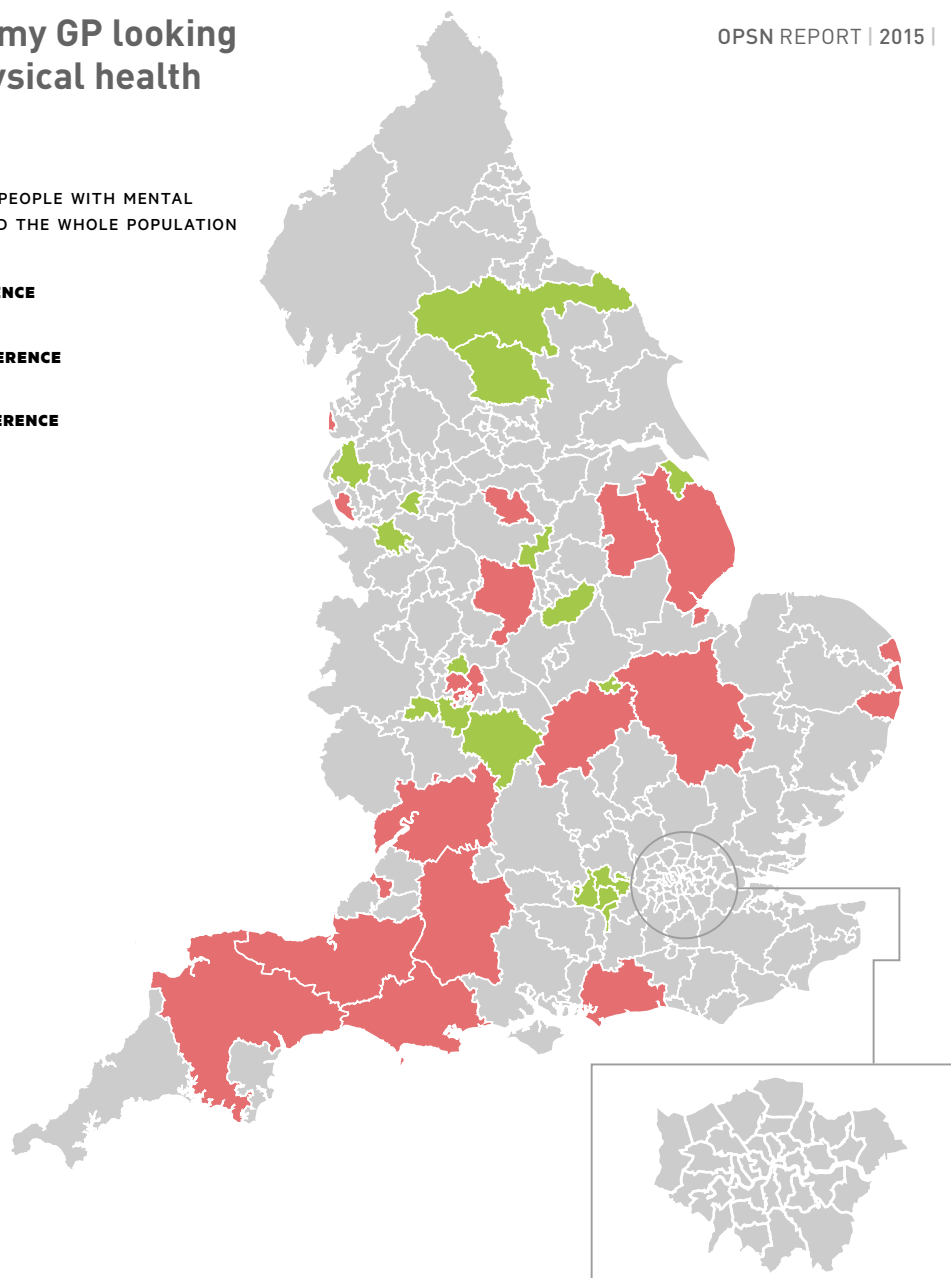
# Access to vital health tests

The background features a vibrant yellow field. In the lower half, there are several overlapping geometric shapes in various shades of orange and light yellow. These include a large semi-circle on the left, a diamond shape in the center, and several triangles and trapezoids on the right side, creating a dynamic, layered composition.

# How well is my GP looking after my physical health needs?

DIFFERENCE BETWEEN PEOPLE WITH MENTAL HEALTH PROBLEMS AND THE WHOLE POPULATION

- LEAST DIFFERENCE**
- AVERAGE DIFFERENCE**
- LARGEST DIFFERENCE**



**CCGs that scored as 'high' in our bandings, meaning a relatively narrower difference between tests given to the whole population and patients with SMI:**

- NHS Bracknell And Ascot CCG
- NHS Corby CCG
- NHS Hambleton, Richmondshire and Whitby CCG
- NHS Hardwick CCG
- NHS Harrogate and Rural District CCG
- NHS North East Lincolnshire CCG
- NHS Redditch and Bromsgrove CCG
- NHS Rushcliffe CCG
- NHS Slough CCG
- NHS South Reading CCG

- NHS South Warwickshire CCG
- NHS Surrey Heath CCG
- NHS Trafford CCG
- NHS Vale Royal CCG
- NHS Walsall CCG
- NHS West Lancashire CCG
- NHS Windsor, Ascot and Maidenhead CCG
- NHS Wokingham CCG
- NHS Wyre Forest CCG

**CCGs that score 'low' in this indicator (meaning there was the greatest difference between tests for people with SMI and the whole population) include:**

- NHS Birmingham Crosscity CCG
- NHS Blackpool CCG
- NHS Bristol CCG
- NHS Cambridgeshire and Peterborough
- NHS Coastal West Sussex CCG
- NHS Dorset CCG
- NHS Gloucestershire CCG
- NHS Great Yarmouth And Waveney CCG
- NHS Lincolnshire East CCG
- NHS Lincolnshire West CCG
- NHS Liverpool CCG
- NHS Nene CCG
- NHS Northern, Eastern and Western Devon CCG
- NHS Sandwell and West Birmingham CCG
- NHS Sheffield CCG
- NHS Somerset CCG
- NHS Southern Derbyshire CCG
- NHS Wiltshire CCG

# Changes to the QOF

Each year changes to the QOF data are agreed by NHS England, NICE and the BMA. In December 2013, it was announced that some of the QOF indicators on cardiovascular and diabetes checks in patients with severe mental illness would be dropped for the 2014/15 collection. This included tests for cholesterol, glucose and BMI. This is of concern to the patients, families and clinicians working with people with psychosis.

Dr David Shiers, an advocate of these types of measurement, told the OPSN:

“This is of considerable concern given that people with severe mental illness die on average 15-20 years earlier than the general population, mainly from potentially preventable physical disorders. For example, the prevalence of type 2 diabetes is two to three fold higher compared with the general population; rates of undiagnosed diabetes are up to 70 per cent in people with schizophrenia compared with about 25 per cent in the general population. The changes to the 2014/15 QOF contract in England will almost certainly undermine systematic monitoring and reduce opportunities to both detect and prevent diabetes, as well as cardiovascular disease, in people with SMI.”

As the cholesterol test formed a part of our composite measure this also puts at risk whether we could repeat our analysis with updated data to provide the same insight. To do so we would need an extraction of this data from local GP practices, which is implausible. It is unclear as to whether an equality impact assessment was undertaken when this decision was made. The OPSN would like NHS England to reconsider this decision for QOF 2016/17.

**“The changes to the QOF contract in England will almost certainly undermine systematic monitoring and reduce opportunities to both detect and prevent diabetes, as well as cardiovascular disease, in people with SMI.”**

# Other analyses

## 2. What is the likelihood of getting access to the right psychological therapies, and what is the outcome if I do?

The National Institute for Health and Clinical Excellence (NICE) published guidelines regarding treatment for depression and anxiety disorders. To help with implementation, the Improving Access to Psychological Therapies (IAPT) programme was launched in 2008. IAPT is an NHS funded programme to improve access to cognitive therapies, peer-to-peer support and self-help guidance<sup>19</sup>. It achieved a considerable political boost in 2011, when a four-year plan of action was published, committing £400 million over four years into the programme to enable 15 per cent of those that need it to access treatment.

Not only does evidence suggest this approach can save the NHS up to £272million and benefit the wider public sector by more than £700 million, but people dealing with mild to moderate depression and anxiety have reported that a course of IAPT therapy is more helpful than pharmaceutical interventions<sup>20</sup>.

To gain a firmer understanding of how successful IAPT has been for people with mental health conditions, OPSN has built two composite indicators to measure both access to psychological therapies and outcomes for those receiving IAPT treatment across the country at CCG level.

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<sup>19</sup> For further reading on IAPT and better outcomes see: de Lusignan S, Chan T, Tejerina Arreal MC, Parry G, Dent-Brown K, Kendrick T. Referral for psychological therapy of people with long term conditions improves adherence to antidepressants and reduces emergency department attendance: controlled before and after study. *Behav Res Ther.* 2013 Jul;51 (7):377-85; de Lusignan S, Chan T, Parry G, Dent-Brown K, Kendrick T. Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems: a before and after comparison. *J Epidemiol Community Health.* 2012 Jun; 66:6

<sup>20</sup> Hewlett, E. and K. Homer (2015) Mental Health Analysis Profiles (MhAPs): England, OECD Health Working Papers, no.81, OECD Publishing, Paris

The panel discussed the relationship between referrals and waiting times, and acknowledged that while waiting times is an important measure of a health system, there are a significant number of patients who are unable to even receive a referral into IAPT.

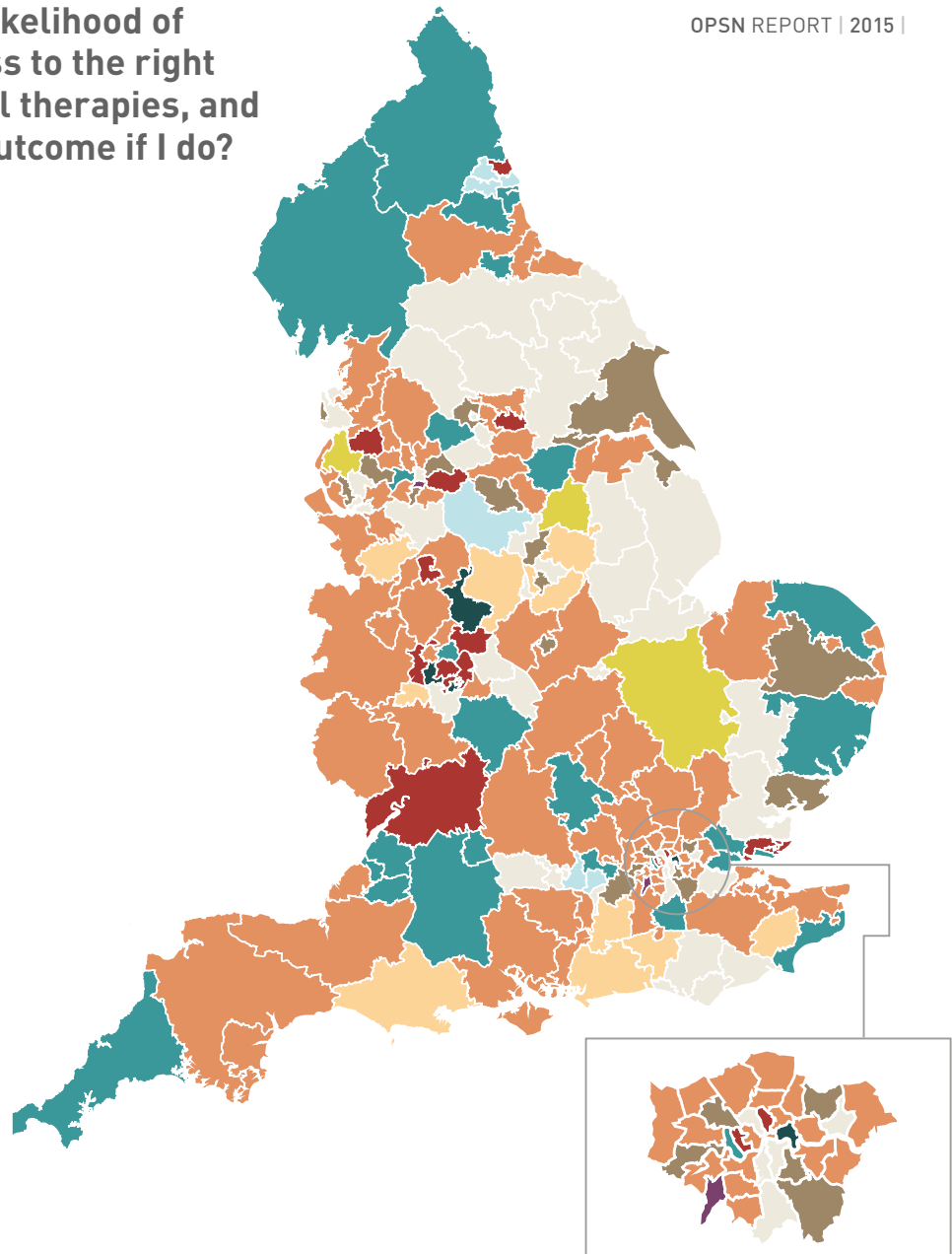
**Access:** we compared access across CCGs by measuring how many people are being referred by their GP to IAPT programmes. We defined an OPSN banding for access to IAPT based on three metrics:

- Rate per 100,000 of the population aged 18+ that are eligible for IAPT.
- People entering IAPT (in month) as a percentage of those estimated to have anxiety/depression.
- Percentage of people waiting less than 28 days.

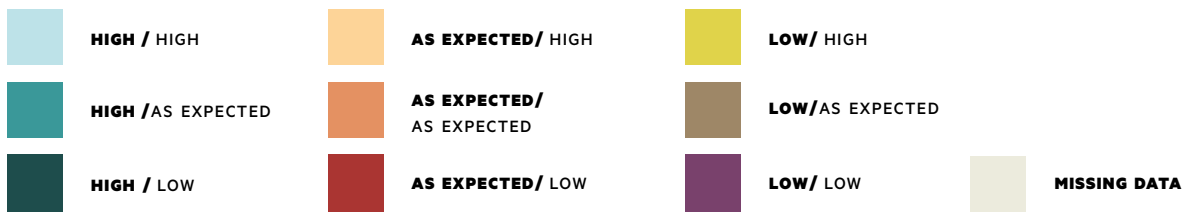
**Outcomes:** we defined outcomes for people receiving IAPT treatment by how many people felt the therapy was of benefit. We gave each CCG an OPSN banding based on four metrics we identified as determining a good outcome:

- Those completing IAPT treatment as a proportion of those entering IAPT treatment.
- Percentage of patients (in quarter) who have completed IAPT treatment who achieved “reliable improvement” as measured by the CCG.
- Percentage of patients entering IAPT service who receive a course of treatment.
- Percentage of people (in month) who have completed IAPT treatment who are “moving to recovery”.

# What is the likelihood of getting access to the right psychological therapies, and what is the outcome if I do?



## ACCESS / OUTCOMES



CCGs that scored 'high' in both access and outcomes to IAPT treatment, meaning there is a higher percentage of eligible people accessing psychological therapies and usually having better outcomes when they do:

- NHS Bracknell and Ascot CCG
- NHS Gateshead CCG
- NHS North Derbyshire CCG
- NHS South Tyneside CCG
- NHS Wokingham CCG

CCGs that scored 'low' in both access and outcomes

to IAPT treatment, meaning there is a low percentage of eligible people accessing psychological therapies and having poor outcomes when they do:

- NHS Central Manchester CCG
- NHS Kingston CCG

### 3. Am I more likely to be referred for psychological therapies or prescribed anti depressants?

The Nuffield Trust and Health Foundation Quality Watch report Focus On: Antidepressant prescribing<sup>21</sup> found that there was a 165 per cent increase in the prescribing of antidepressant drugs in England between 1998 and 2012; an average of 7.2 per cent a year.

NICE recommends referring people for non-drug therapies as the mainstay of treatment for many people with depression, with drugs generally reserved for more severe illness or when symptoms have failed to respond to non-drug interventions<sup>22</sup>.

OPSN has compared prescribing rates for antidepressants to referral rates for IAPT services. As shown on the following map.

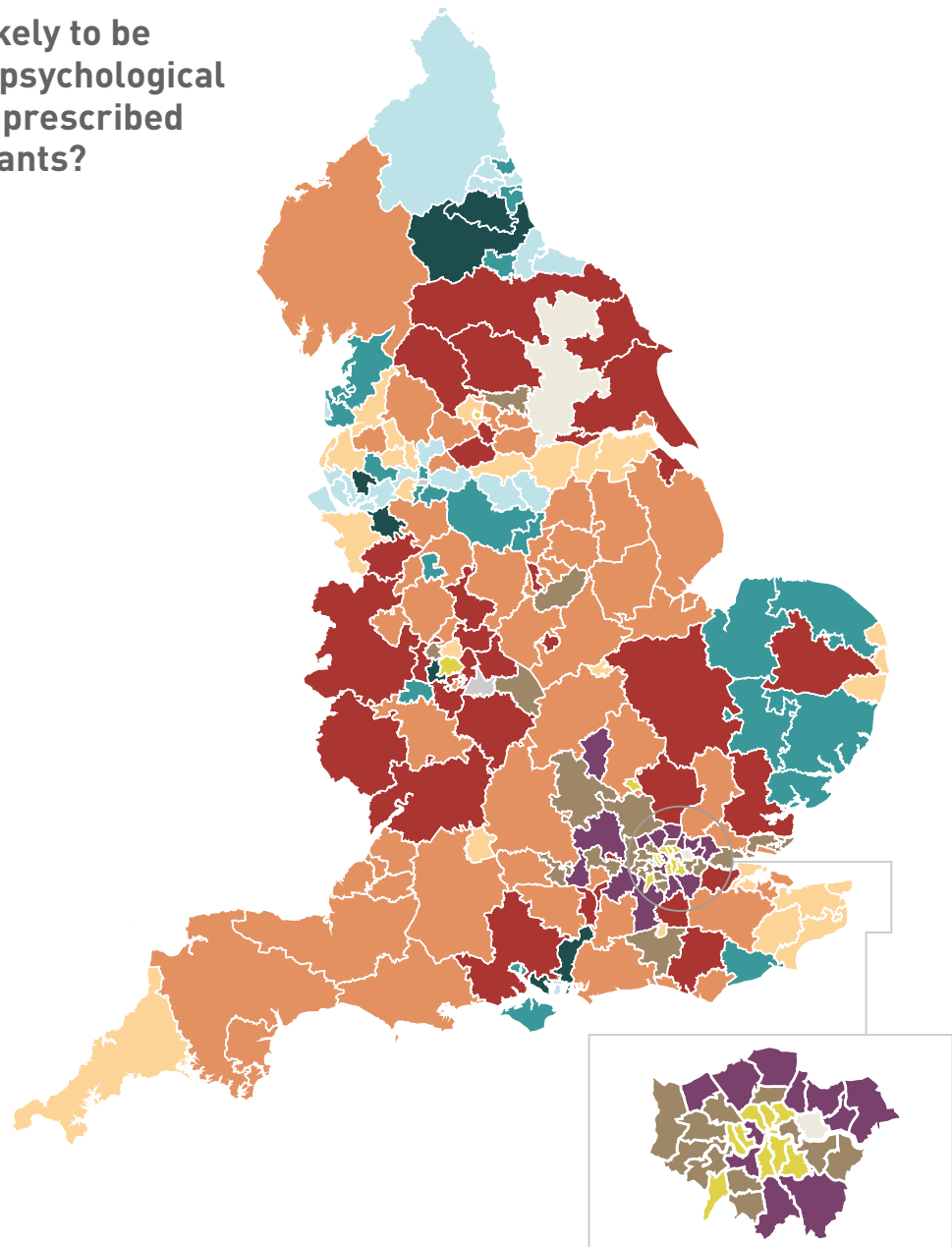
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<sup>21</sup> Focus On: Antidepressant prescribing, trends in prescribing antidepressants in primary care, The Health Foundation and the Nuffield Trust, 2014

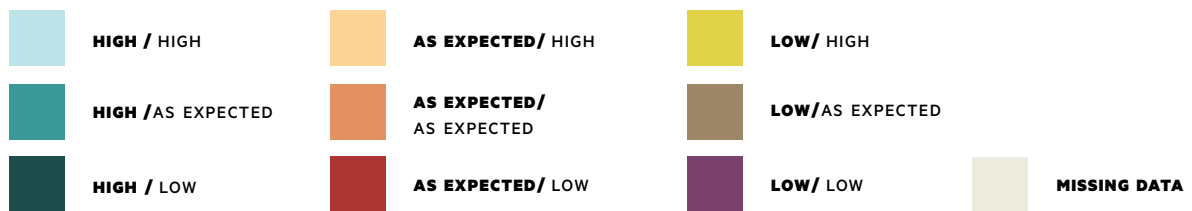
<sup>22</sup> <https://www.nice.org.uk/advice/ktt8/chapter/evidence-context>



# Am I more likely to be referred for psychological therapies or prescribed anti depressants?



## PRESCRIBING / REFERRALS FOR IAPT



### CCGs with a low referring rate for IAPT and a high prescribing rate:

- NHS Durham Dales, Easington and Sedgefield CCG
- NHS Fareham and Gosport CCG
- NHS North Durham CCG
- NHS South Eastern Hampshire CCG
- NHS St Helens CCG
- NHS Vale Royal CCG

### CCGs with a high referring rate for IAPT and a low prescribing rate:

- NHS Bradford City CCG
- NHS Camden CCG
- NHS City and Hackney CCG
- NHS Hammersmith and Fulham CCG
- NHS Islington CCG
- NHS Kingston CCG
- NHS Lambeth CCG

- NHS Lewisham CCG
- NHS Luton CCG
- NHS Sandwell and West Birmingham CCG
- NHS Southwark CCG
- NHS West London CCG

## 4. How well am I supported to live well with my condition?

As we know, socio-economic factors have a large effect on health outcomes<sup>23</sup>. Therefore, when looking at health outcomes for people with mental health conditions, we have assessed employment status, living conditions, and whether they are receiving career advice.

The OPSN has demonstrated that people with a mental health condition are less likely to be in work, less likely to be living in settled accommodation, and more likely to be in contact with social care services, all important indicators of life satisfaction. These different factors also stem from where a person lives. Therefore OPSN has mapped the support of people with mental health conditions across local authorities.

We looked at how well people with mental health conditions are being supported by their local authority by measuring whether people are receiving good care and support. We used eight indicators to measure this:

- Satisfaction with social care support: percentage of service users extremely satisfied or very satisfied with their care and support.
- Employment of people with mental health disorders: percentage of those who are in employment.
- Gap in employment: percentage gap between the employment rate of those with mental health disorders and the overall population.
- CPA adults in employment: percentage of people aged 18-69 on CPA in employment.
- Self-directed payments: percentage of social care mental health clients receiving direct payments.
- Self directed support: percentage of social care mental health clients receiving direct payments or a personal budget.

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<sup>23</sup> [http://www.noo.org.uk/N00\\_about\\_obesity/inequalities](http://www.noo.org.uk/N00_about_obesity/inequalities)

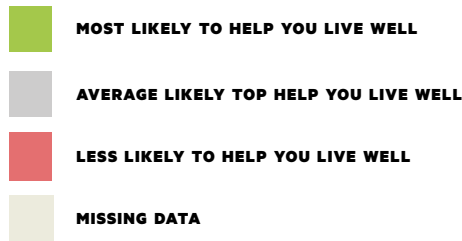
- Carers of mental health clients receiving services: carers receiving services or advice or information as percentage of mental health clients receiving community services.
- Per cent of people aged 18-69 on CPA in settled accommodation.

CPA refers to the Care Programme Approach, an integrated approach to service delivery for individuals with complex needs. By opening access to its data, we are hoping to map out the contrasting life outcomes of those with physical and mental health difficulties.

36 local authorities had insufficient data available to analyse with enough confidence to achieve a banding. This highlights the difficulty of comparing localities and getting a coherent national picture. As shown on the following map.

# LOCAL AUTHORITIES

## How well am I supported to live well with my condition?



**Local authorities scoring an OPSN banding of 'high', meaning they have been rated relatively successful (according to our eight indicators) in helping people with mental health conditions to live well:**

- Bath and North East Somerset
- Bedford
- Derbyshire
- East Sussex
- Herefordshire
- Norfolk
- North East Lincolnshire
- North Somerset

- Nottinghamshire
- Redbridge
- Shropshire
- South Tyneside
- Stockport
- Sutton
- Wigan
- Wiltshire
- Worcestershire

**Local authorities scoring an OPSN banding of 'low', meaning they have been rated poorer at helping people with mental health conditions to live well:**

- Bexley
- Bradford
- Brent
- Coventry
- Doncaster
- Hackney
- Havering
- Hounslow
- Kingston upon Thames
- Lambeth
- Middlesbrough
- Peterborough
- Sheffield
- Westminster

# Recommendations



In the course of our research the OPSN has concluded a number of recommendations for better care and for data access:

- 1. GP practices and practice managers: NHS England in its role as direct commissioner of primary care and CCGs should ensure that all eligible people with severe mental illness are systematically screened for diabetes and cardiovascular risk, and the rates of responsive treatment recorded.**
- 2. There should be a rapid comparison of the model of primary care mental health and how people with SMI can best be engaged to ensure their health improves.**
- 3. Smoking cessation should be properly offered to everyone with a mental health condition (not just a question asked by GPs to fulfil QOF requirements).**
- 4. Every clinical team, research institution and other responsible organisations should have far greater access to health information linking primary and secondary care data. The HSCIC should be tasked with making this happen quickly and effectively.**
- 5. The HSCIC should also make it easier for researchers and responsible organisations to access linked hospital episode statistics with the mental health minimum dataset. Data requests should be processed in a timely manner.**
- 6. The changes to the QOF are unhelpful and NHS England should consider reverting to the old indicators, with GPs being asked to incentivise tests of glucose, lipids and BMI for people with SMI. NHS England should commission an urgent review of this decision.**

- 7. Local CCGs and local authorities should provide routine feedback to every GP practice and local commissioned secondary care provider of the extent to which they are meeting national evidence-based standards of assessment and care of those with mental ill health.**
- 8. Data about years of life lost for people with SMI should be recalculated to give an average number of years per local authority or CCG (the 'life expectancy gap'). This is available for the whole population<sup>24</sup> but not for people with SMI.**
- 9. Public health leaders should urgently agree a systematic review of the successful public health strategies to improve the physical as well as mental health care of people with mental ill health and especially those with SMI.**

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<sup>24</sup> <https://www.nhs.uk/Service-Search/performance/results?SortingMetricId=8174&ResultsViewId=1075&OrgsOnPageInShortListAsPageLoads=&EntityCode=LA&InShortList=False&DefaultLocationText=Please+enter+a+location+or+postcode&DefaultSearchRadius=25&CurrentSearchType=Full&MetricGroupId=504&LocationName=Please+enter+a+location+or+postcode&LocationId=0&OrganisationNameSearchValue=&PageSize=10>

# About the OPSN

The Open Public Services Network (OPSN) is a programme based at the RSA providing independent assessment of government and public services performance data.

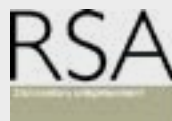
OPSN works to improve the debate surrounding the quality and value of information available to the public about education, health and other key services, and measure impact and value for money in ways that make sense to and engage the public.

We are committed to supporting the delivery of the most efficient, effective and highest quality public services that we can afford. OPSN will advocate and showcase better use of information and technologies, especially online communication tools, to improve public understanding and use of public services.

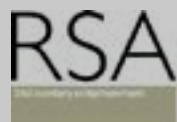
This is our first project examining health, specifically mental health, services in the UK. Other reports have focused on pupil attainment in schools, both at GCSE and A-level.

Visit [www.thersa.org/opsn](http://www.thersa.org/opsn) for more information.

To discuss with this project further or to participate or fund further projects with the OPSN please contact Charlotte Alldritt on [Charlotte.Alldritt@rsa.org.uk](mailto:Charlotte.Alldritt@rsa.org.uk)







Cabinet Office

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