City and Hackney Adult Mental Health Joint Strategic Needs Assessment

Part 3: Local Challenges and Recommendations

2025

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Abbreviations and acronyms

ACH:	African Caribbean Heritage
ELFT:	East London Foundation Trust
GP:	General Practitioner
LGBTQIA+:	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities
NHS:	National Health Service
SMI:	Severe Mental Illness
TTAD:	Talking Therapies of Anxiety and Depression
VCS:	Voluntary and Community Sector
WBN:	Wellbeing Network

1. Introduction

This report summarises the challenges identified in the City and Hackney Mental Health JSNA - Part 1: The Local Picture and Part 2: Local Services and makes recommendations for how to address these. Four main themes emerged:

- Difficulties experienced by residents in accessing and navigating local mental health services,
- Inequalities in mental health need and how inclusive services are,
- Gaps in the quality of insight, driven by fragmented data and inconsistent approaches, limiting effective decision-making,
- The underlying accountability and governance structures for mental health.

While discussed the least in the reports, the accountability and governance issues appear to underpin the other three and their success is likely to be limited if these governance and accountability issues cannot be solved.

Also underlying all of the challenges outlined below are high levels of mental health needs in the City and Hackney.

- Rates of common mental health conditions have been increasing in the City and Hackney over the last decade, reflecting national trends.
- Hackney's rates of common mental health conditions are higher than the London average, though similar to England.
- Rates of severe mental illness (SMI) have remained relatively stable in the last decade but Hackney's rates are about 50% higher than the London and national averages.
- While the City of London's rates of SMI and common mental health conditions are lower than the national and London averages, there are still some communities with high levels of mental health needs.
- Often some of the greatest levels of need are found where mental health intersects other areas of need.
- Despite the increasing mental health need, there is already insufficient funding to meet demand. This is likely to be a challenge for the foreseeable future.

2. Navigating and Accessing Services

One of the most common complaints from stakeholders and residents is that mental health services are complicated to navigate.

The challenges raised include:

- There are a **number of different services** and it is **difficult for residents and support workers to know which is most appropriate for who.** Support workers report that they often make a referral to a general practitioner (GP) or emergency services, rather than to the correct service due to this.

- Staff from wider support services can be valuable in helping residents to navigate systems. However, it is arguably **not realistic to expect them to have in-depth knowledge of all mental health services, the types of mental health and other relevant intersecting factors, in order to know which service to recommend** in each case. Mental health is just one of many issues resident-facing staff frequently encounter and some of these staff have requested a single point of referral for mental health.

- **Many residents are initially referred to the wrong service**. Some are then referred on to a more appropriate service and others are told they are not eligible and perhaps given some generic information on other support available. This can all be time consuming and therefore costly to the original service, as well as a negative experience for the resident, who may not persist with help seeking.

- **When residents do move between services they get frustrated repeating themselves multiple times**. Work was undertaken a few years ago to try and design a shared referral form but the challenges around different data systems, different collection requirements and information governance proved insurmountable at the time.

- **Some services require a GP referral** and do not have a self-referral option, including many East London Foundation Trust (ELFT) services. **This can add extra steps for residents in getting support** and **excludes anyone not registered with a GP**. It may also put off anyone who does not have a good relationship with their GP or struggles to get GP appointments. While Talking Therapies for Anxiety and Depression (TTAD) allows self-referrals, it does require GP registration.

- **Long waiting times** are one of the most frequently raised concerns and can mean that **by the time a resident is seen by services their condition has deteriorated or their willingness to engage and trust services has been eroded**. Many services do have fairly low average waiting times, so more information on where the issues are occurring would be helpful to understand where action is needed.

- **A high proportion of residents drop out of larger commissioned services** (It is unknown whether this includes ELFT as their data were not made available). Very little is known about why these residents drop out having asked for help, or who they are (e.g. whether some population groups are more likely to drop out).

- Even when residents are accepted into a service, **the support may not last long enough or lead to recovery,** and their condition may deteriorate. They may keep seeking help from other services or present again in a more serious state, e.g. crisis. Ensuring residents get the right care earlier could lead to better outcomes and experiences, as well as save resources.

- **Some residents require ongoing support** as a result of their condition but there is very limited ongoing provision available.

- **Residents with complex needs often need to go to a different service for each of their needs**. This can be very difficult for people who may already be experiencing chaotic and challenging lives. Residents report wanting to be able to go to one place (or at least fewer places) for all their needs and **many support services and resident representatives advocate for more mental health outreach/in-reach.**

- **Some residents are excluded from mental health services due to co-occurring needs,** such as substance misuse. They often do not have the option to be supported for multiple needs by one service (or by organisations working in partnership).

- While for many they are effective, **some residents don't feel the mental health interventions available are well suited to their needs.** Some feel that they have a Western or white bias and focus too much on talking therapies, when there are other ways to support mental health.

- **Even when signposted to mental health services, many residents will not follow through**, sometimes because that key moment of help-seeking has passed or because they do not trust the signposted services. Therefore, capitalising on when and where residents are receptive could be beneficial. This could include in-reach to other services or upskilling staff from wider services.

- **There are currently limited external opportunities for resident-facing staff from wider support services to train in mental health awareness**, signposting, starting conversations and giving basic advice, **meaning many staff lack these key skills**. It could be argued that for many staff this training is essential to their role and therefore should be funded internally but most wider services believe mental health services should provide this training.

Recommendations - navigating and accessing services

- "A single point of coordination/hub for all local mental health services. Exactly what this involves would need to be worked up.
- Consider how best to help residents and support services identify the most appropriate mental health support. This could involve:
  - creating a flowchart/pathways diagram (acknowledging previous attempts at this have gone out of date very quickly and still been very complicated),
  - visiting external services to explain the different options available, who is most suitable for which service etc.,
  - adopt an AI tool to help residents identify the best support for them.

  (This recommendation may be superseded by a single point of coordination if that could be established).
- Introduce more in-reach and outreach options, especially in services where there are many people with high and complex mental health needs.
- A piece of work to look in more detail into waiting times and delays and make specific recommendations based on findings.
- A further joint piece of work to look into how many residents require longer term or ongoing support, what sort of support they need (also taking into account the evidence base in terms of effectiveness). Longer term support could include community activities and peer support.
- Create a training offer for resident facing (non-mental health) staff on mental health awareness and how to offer basic advice and signposting. Perhaps pre-recorded/online.
- Services to do warm referrals where possible, prioritising population groups who are most excluded from mental health services.

- ELFT to look into whether more self referral options could be introduced for their services where this is possible and appropriate.
- Monitor what is happening in other areas and nationally in terms of shared referral forms and related technological developments that we might be able to implement in the City and Hackney.

3. Inequalities and Inclusivity

While important improvements have been made in relation to inequalities in some areas, many still persist, This section covers some of these by theme or population group, with some overarching themes listed below.

- **Some residents are not easily able to attend services at the main location(s), due to factors such as travel costs and time.** Some residents have difficult and complex lives and may need to prioritise practical issues over attending mental health services. These issues affect certain population groups more and often those that most need the support, such as those living in deprivation and asylum seekers. Outreach and in-reach services can be effective for improving accessibility for these groups but there are limited options for mental health.

- **Some residents are reluctant to attend mainstream NHS services, often lacking trust, fearing discrimination or a lack of cultural sensitivity and worrying how their personal details will be used.** Some have had previous negative experiences. These concerns are more prevalent in certain population groups, including Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and all other related identities (LGBTQIA+) residents and some global majority communities. Alternative community based support is often highly valued by these groups, though funding for this is comparatively limited and often more at risk of funding cuts.

- **Voluntary and community sector organisations play an important role** in supporting some of City and Hackney's diverse communities, especially where communities are reluctant to attend mainstream services. **However, these organisations have recently experienced significant cuts** to their already comparatively limited funding, against the backdrop of increased need.

Sexual orientation

- There is a lack of local data on mental health needs for LGBTQIA+ communities in the City.
- Most services, including ELFT and TTAD, either do not collect data on sexual orientation or do not collect it routinely enough for analysis to be meaningful, so it is not possible to know how well services are meeting the needs of LGBTQIA+ populations.
- Stakeholders and resident representatives report that LGBTQIA+ communities can be reluctant to access mainstream services due to concerns such as fear of discrimination and not being understood.
- The Wellbeing Network (WBN) and TTAD (via Mind in the City, Hackney and Waltham Forest) do include a specific LGBTQIA+ pathway, although funding for the WBN is currently due to end by July 2027.
- In the WBN, the only service where sexual orientation data was available, LGBTQIA+ groups had lower improvements than heterosexual/straight residents, following interventions, although in both groups improvements were clinically significant.

Ethnicity

- SMI rates for black ethnicity groups and the mixed white and black Caribbean ethnicity group are the highest locally. However, African and Caribbean heritage (ACH) groups are significantly underrepresented in ELFT's community services.
- The mixed white and black Caribbean ethnic group has the highest rates of depression and anxiety in the City and Hackney, followed by white British and white Irish ethnic groups.
- Stakeholders and resident representatives report that some global majority communities can be reluctant to access mainstream NHS services due to concerns such as fear of discrimination and a lack of cultural competency.
- In some organisations, such as TTAD, staff are disproportionately white British, compared to the local population. This may partly be a reflection of wider issues, such as diversity in those pursuing careers in psychotherapy.
- In the WBN, ACH ethnicity groups had lower improvements than non-ACH residents, following interventions, although improvements for both groups were clinically significant. In TTAD the 'Asian or Asian British' ethnicity group had significantly lower overall recovery rates than average.

Deprivation

- People living in the most deprived areas of the City and Hackney have the highest rates of common mental health conditions and SMI. However, they appear underrepresented in TTAD, the WBN and to a lesser extent ELFT.

- People from the most deprived neighbourhoods are disproportionately likely to have complex lives and multiple needs, meaning they may be less likely to be able to attend mental health services.

Gender

- In the City and Hackney women have higher rates of common mental illness than men but men have higher rates of SMI. It is not clear how much of these differences are due to genuine differences in prevalence and how much is due to other factors, such as lower awareness and acceptability in men and possible overdiagnosis of common mental health conditions in women.
- Even taking into account their differing prevalence of mental health conditions, men are underrepresented in TTAD, the WBN and ELFT community services. It is not clear how much of this underrepresentation of men reflects social factors and how much it is that services and the interventions offered are not sufficiently inclusive to men.
- In the WBN, the data indicate that men on average have lower wellbeing improvements following intervention than women. In TTAD there was no significant difference in recovery rates by gender.

Age

- Residents aged 40-74 had the highest rates of depression, those aged 25-39 had the highest rates of anxiety and 50-74 year olds had the highest rates of SMI in the City and Hackney.
- Residents aged over 45 appear underrepresented in ELFT community services and TTAD, with the exception of the 70+ age group in ELFT.
- In the WBN, the reverse trend is true, with age groups up to 34 being underrepresented.

Complex mental health needs

Many stakeholders continue to raise concerns about the increasing number of residents with complex mental health needs and how it is especially difficult for them to get mental health support. The situation is only likely to get worse with services aimed at supporting this population group ending. PCPCS recently lost its funding and the current WBN is due to end in July 2027.

Complex needs clients often are not well suited to traditional mental health services and due to the nature of their complexity. Supporting them requires proportionately more resources than average. Due to their negatively reinforcing complexities, without the right support these residents are likely to deteriorate and be at high risk of needing even more expensive support, such as crisis or inpatient services. However, the WBN model has shown that it is possible to get good outcomes from these clients, not just on wellbeing measures but also around other factors such as employment, physical health and isolation.

Residents living in temporary accommodation

- Residents living in temporary accommodation have high levels of mental health needs and these are usually complex needs. The number of households in temporary accommodation is rising, with Hackney ranking among the highest.
- Primary care and some mental health services do not routinely record a person's accommodation status. Completion rates are low for those that do.

Residents experiencing rough sleeping

- The City of London has the third highest rate of rough sleeping in London and the majority of rough sleepers have mental health problems and for many this is a factor in their becoming homeless.
- Traditional services are often not well suited to rough sleeping populations.
- People rough sleeping usually have complex and intersecting needs. Once they are at the point of sleeping rough, it can be very difficult to deliver successful interventions, so earlier intervention is key.

Gypsy and traveller communities

- There is high unmet mental health need in the local gypsy and traveller communities.
- Gypsy and traveller status is not systematically recorded by many health services and some residents also choose not to disclose this, so data are limited.
- Outreach is vital for engaging with these communities but there is little available for mental health.

Refugees and asylum seekers

- While there are no quantitative data available, professionals working with refugees and asylum seekers report a high prevalence of mental health conditions in this group
- Traditional mental health services are unlikely to be well suited to this group. In-reach and outreach services are likely to be the most beneficial.

Recommendations - inequalities and inclusivity

- Further work to look in more detail about how services can be more inclusive for underrepresented population groups, including:
    - LGBTQIA+ communities,
    - Men,
    - Global majority ethnicity groups, where they are underrepresented,
    - Residents living in most deprived areas,
    - Gypsy and traveller communities.

  Perhaps including specific interventions or pathways and learning from good practice where services already have representative uptake from these population groups.
- Use outcomes data across all services to study in more detail the difference in outcomes for different population groups. Where one group is getting poorer outcomes, investigate what may be causing this.
- Define, record and if possible quantify complex mental health needs across services, so that the extent of this need can be better quantified and understood. It may be that this is defined using more than one category, such as ‘complex’ and ‘significantly complex’ needs. It is also acknowledged that any definition or classification will be imperfect but even a proxy could help to quantify and understand the extent of this issue.
- Ensure there are services in place and appropriate pathways for people with significant complex mental needs to access the support they need, in a joined up and holistic approach, keeping in mind local authority funding for the WBN, which currently provides this, has significantly decreased and will end in July 2027, so this service will cease unless alternative funding can be secured.
- Offer more community based and in-reach/outreach interventions, including at locations where people with multiple needs will already be attending and areas of high deprivation.
- Invest in more alternative interventions, including culturally appropriate interventions and interventions more suited to men, to complement the clinical/therapeutic offer. There is currently a lot happening in this space but it is underfunded and more is needed.
- Provide early, seamless mental health support that prevent escalations to secondary care, reduce service fragmentation and alleviates pressure on hospital beds, improving residents' care journey.

- Services to improve recording of sexual orientation, accommodation status and any other agreed metrics (see data) so we can better understand any unmet need.
- Review how best to offer mental health support to asylum seeker and refugee populations groups, including how to ensure an inclusive offer and to take into account their concerns around information sharing and their relatively transient nature.
- Ensure residents with learning disabilities and autism experience minimal inpatient delays, faster discharges, with enhanced care quality, and better access to mainstream services, especially from marginalised groups.
- Work with housing, homeless and temporary accommodation services to understand how mental health services can be more inclusive to these populations and take action on this. including targeting this work where it is most needed, for example families living in temporary accommodation.
- In partnership with other services, ensure that people who are at risk of homelessness get the support they need urgently for their complex mental health needs and ADHD to prevent them becoming homeless in the first place.
- Ensure there is support in place to access training and qualifications in psychotherapy, or other roles within mental health, with a specific focus on population groups that are underrepresented in current staffing. Good practice already in place by organisations such as Mind in the CIty, Hackney and Waltham Forest should be built upon and shared.
- Continue to monitor national research and best practice to better understand high rates for SMI diagnosis and inpatient admissions for ACH population groups. ELFT to continue work to ensure ACH patients are correctly allocated to community or inpatient services, acknowledging the underpresentative and overrepresentative rates of ACH patients in these services respectively.

4. Knowledge, Insight and Decision-Making

Services and wider stakeholders broadly agree that better mental data and more transparency and sharing of these data would be hugely beneficial. However, there are a range of challenges related to this.

Insufficient data available or shared

While the JSNA highlights many important key insights, there are gaps in the available mental health data that limit full understanding of local mental health needs, how well services are performing and for which communities. This can make it more difficult for decision makers and commissioners to make evidence-based decisions, on a strategic, system wide level and possibly even within services. These gaps arise because some data are not routinely collected, limited sharing and transparency.

No overall oversight and accountability

Data requirements and reporting for each service are governed by different responsible authorities, on different geographical footprints. Data tend to be reviewed on an individual service basis, with no whole system view. This makes it very difficult to use data to inform strategic decision making for City and Hackney as a whole. The City and Hackney Mental Health JSNA - Part 1: The Local Picture and Part 2: Local Services reports aimed to change this and bring together all local mental health data. However, obtaining the data proved difficult and prolonged and there are still some gaps, because data did not exist or was not provided, including demographic data, such as sexuality, some outcomes data and information on complexity of needs. Obtaining data from ELFT was especially difficult. Getting data from voluntary and community sector (VCS) organisations is also a significant challenge for different reasons and the lack of this means that their contribution to the system is not as visible or recognised.

Different Data Systems

A contributing factor to the problem of sharing data is that each mental health service uses its own system for collecting and processing data. There is some linkage between the NHS services but it is limited and VCS organisation systems are completely separate. Even the VCS TTAD providers use a different system to submit their data to NHS England from the Homerton and these two data systems do not connect to each other. An additional related challenge is that the small size of VCS organisations can make obtaining high quality data systems difficult, which can lead to challenges in data management and increase the amount of staff time required to process it.

Additional data challenges

More specific data related challenges are listed below.

- Primary care data suggest that recorded rates of common mental health conditions in Hackney have been broadly similar to those seen nationally over the past decade. In contrast, **the Adult Mental Health Population Survey (AMPS) conducted in 2014 indicated much higher levels of self-reported mental health problems locally**. These findings are not directly comparable, as population surveys and primary care records use different definitions, thresholds, and methods for identifying mental health needs. However, they point to **the likelihood that more people are experiencing mental health difficulties than are currently diagnosed in primary care**. This suggests a level of unmet need in the local population and warrants further investigation to better understand its scale and nature.

- **Data on outcomes, such as overall improvements in wellbeing, as a result of interventions, are not well collected by some services**, or not in a way that is useful in terms of understanding the effectiveness of interventions. This includes ELFT services.
- **Completeness of data for end of treatment measures (to allow beggining/end comparisons) are often limited** due to people dropping out or not completing this. Without these data, it is difficult to understand treatment effectiveness and acceptability across a range of measures. improving wellbeing for different population groups.
- Current understanding of mental health needs is largely shaped by people who use services, meaning **less is known about those who never seek help or who disengage once support has started.** Improving insight into the experiences, barriers, and reasons for non-attendance or drop-out would help inform more accessible and effective mental health support.
- **There is a lack of data available from VCS organisations**, despite the significant role they play in providing mental health support locally. Access to quality data systems, capacity and in some cases expertise, contribute towards this problem.
- **Recording of some demographic and social characteristics is often incomplete**, particularly for sexual orientation, marital status, employment, accommodation status, disability, and physical health. This limits how confidently patterns can be explored across these groups.
- **Ethnicity is not categorised in a consistent or sufficiently meaningful way in local mental health data.** For example, some key local population groups, such as Turkish/Kurdish and Orthodox Jewish are not well captured in most datasets but are significant locally and local mental health services include specific provision for them.

- **There is no formal way for services, including GPs, to record or report complex needs**. This is despite it repeatedly coming up as an area of increasing and unmet need. Not being able to quantify or track this need across services and the local population makes it difficult to make evidenced-based decisions.
- **Data are often not comparable across services**. Some of this is due to mental health services recording different metrics depending on their service design. However, they also sometimes use different formats to record the same metrics (e.g. different ways of categorising ethnicity) and use different methods to measure the similar things, such as wellbeing improvement. Even the definition of a 'referral' can vary across services.
- **Many patients have privacy concerns** and do not understand how services will use their data. Additionally **not all resident-facing staff understand or are not able to explain how patient data will be used.**
- A number of **non-mental health support services** collect data on mental health (or could), **which could provide an estimate of changing mental health trends locally.** However, this is not always well completed, shared or reported in a way that would allow it to be used this way.

Recommendations - Knowledge, Insight and Decision-Making

- Consider whether a coordinated approach to data management systems and recording would be possible for VCS organisations, which may create efficiencies for them and support recognition and visibility. For example, investigate whether a shared data management system could be commissioned across a range of VCS organisations, to enable them to access a higher quality system than would be possible individually.
- Agree a proportionate minimum dataset that should be collected consistently across mental health services, to be shared with key strategic stakeholders. The purpose of a minimum dataset is to ensure that a basic, shared evidence base exists to support system-wide insight, equity analysis, and strategic planning across different types of mental health provision. It would not replace existing service monitoring and performance management mechanisms. This minimum dataset should focus on a number of core measures that enable meaningful analysis across population mental health and mental health services (for example, rates of mental illness, demographic information, waiting times, and broad

outcomes). Any agreed dataset should be developed collaboratively with providers to ensure feasibility and relevance, and reviewed periodically as services and priorities evolve. This should include VCS organisations where possible, to ensure they and their contribution is visible and valued within the system. Residents should also be engaged to understand what measures are most important to them about mental health services.. While data will be considered across the system, it will be against a background of understanding that different service data will not always be comparable, For example outcomes data will not be directly comparable due to different starting types of mental health condition, variations in severity and complexity, different types of interventions and different lengths of care provided.

- Agree and develop a mechanism for sharing and using the minimum dataset, such as a data dashboard. This could be local or it may be possible to advocate for this at an ICB, national or regional level.
- Where possible and reasonable to do so, standardise the collection of the agreed demographic and inequalities measures across all mental health services and put in place processes to ensure high completion rates for these. This includes what measures are collected, how questions are asked and the response option categories (e.g. ethnicity categories). The response options should take into consideration national norms as well as the local population, e.g. recording of Turkish/Kurdish and Charedi Jewish identities.
- Investigate whether it is possible or beneficial to align the data management systems of the various services at all, to support integration of the system and improved patient experience. .
- Improve the recording and understanding of people's journeys through mental health services, including engagement, non-attendance, drop-out points and outcomes following contact with services. This should cover people who disengage at different stages of the pathway, as well as those who never attend or do not progress to treatment, and capture (where appropriate) the reasons for this. Better information on engagement patterns, alongside demographic characteristics, would support a clearer understanding of where and for whom services may not be working as intended, and whether some population groups are disproportionately affected.

- Develop more proactive, partnership-based approaches to identify and respond to mental health needs among people who do not access, disengage from, or are not currently known to mental health services. This includes working with wider system partners such as primary care, education, housing, employment, community and voluntary sector organisations to recognise mental health needs that may present indirectly or alongside other issues. Responses should not rely solely on clinical pathways, but include social, community-based and preventative support where appropriate, recognising the role of factors such as loneliness, isolation, insecurity and wider life pressures in shaping mental health and wellbeing.

- Improve how information about data use is communicated and understood by both staff and residents. This includes supporting resident-facing staff with clear, consistent messages and practical guidance so they feel confident explaining why data are collected, how they are used, and how privacy is protected. Alongside this, develop simple, consistent communications for residents that show how shared data contribute to better understanding of need, fairer decision-making, and service improvement. Over time, this should help build trust, support informed engagement with services, and improve the quality and usefulness of data collected.

- Consider how data from non-mental health support services could be used to monitor trends in prevalence and demand and work with these services to ensure this is included in MH data oversight and strategic planning.

5. Governance and Accountability

Many of the challenges outlined in this report are underpinned by the underlying governance, accountability and structure of local mental health services and systems. Some of the main factors are outlined below:

- **Each service is accountable to a different organisation, often with different geographical footprints.** The WBN reports to City and Hackney Public Health, TTAD to NHS England and ELFT to North East London Integrated Care Board. VCS organisations report to their own boards for self-funded activity and external commissioners for external contracts.

- **Each service has its own remit, objectives and targets, with each working to make their own service better,** which to a degree makes sense. However, as no service is responsible for the whole population's mental health, this can create gaps in provision and responsibilities. Even if every service performs perfectly, gaps would remain.

The two largest local services, ELFT and NHS Talking Therapies, broadly treat people with SMI and common mental health conditions respectively[1], and do so with a clinical approach, centered around talking therapies. While this can be effective for many patients, it can exclude those with needs that do not fall under these categories or services, for example:

  - Residents with complex mental health needs where they are are too complex for TTAD but don't have an SMI or otherwise meet the thresholds for ELFT. These residents often need a whole person, holistic approach to care.
  - Where a medicalised or therapeutic approach does not meet residents' needs. Some people respond better to or are more willing to engage with activity, social or skill-based interventions.
  - For some, cultural acceptability or stigma may make them reluctant to attend NHS mental services. Trust concerns regarding NHS services, sometimes because of previous experience of discrimination, or a lack of cultural competency.

- **No single body, service or commissioner has overall responsibility or accountability for mental health in its totality** for City and Hackney. As a result there is no overarching authority to determine who should be accountable for what, or who should meet gaps in provision, Therefore inequality of mental health needs will inevitably persist.

- The NHS commissions these more clinical services and its responsibility in doing so is fairly clear. **However, there appears to be less agreement on who should fund or deliver more holistic and activity based mental health interventions**. Despite this, most stakeholders do support and recognise the importance of this type of care in principle.

- There are a number of boards that try to bring together different stakeholders and services, such as The Mental Health Coordinating Committee, Psychological Therapies and Wellbeing Alliance and the Mental Health Strategic Group. However, **there is no one board that all services are truly accountable to, has responsibility for the strategic direction for all mental health services or has the authority to define who is responsible for the gaps in provision.**

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[1] At the moment some residents with complex needs can be seen in the WBN, a community service offering a holistic approach. However, funding for this service has just been significantly reduced and will end entirely in 2027. PCPCS, an NHS service for residents with complex needs, was also recently decommissioned. Some non-clinical and/or community based provision is offered but it is a small proportion and much of this funding is uncertain.

- While theoretically commissioners and providers could agree additional responsibilities among themselves, in an environment of ever tightening budgets and already insufficient resources, this will be very difficult to achieve.

- While there are a number of roles that have system level responsibilities across the sector, including in the Integrated Care Board, ELFT, public health and the voluntary sector, the exact overall strategic responsibilities of these roles and how they interact is unclear.

- **Service targets rarely encourage integration or accountability to the system as a whole and can actually discourage partnership working.** For example, ensuring that residents receive a warm referral to a more suitable service takes significant resources, which could otherwise be used to help meet KPIs. Sometimes different mental health services even have to compete for funding, further discouraging collaborative working.

- **Improved integration of services and partnership working** could potentially help but with the current system of services and without well functioning governance underlying it, the impact of this is likely to be limited.

- **The system is predominantly designed around services and how they work, not around residents and how they need support,** especially not more marginalised residents.

Recommendations - governance and accountability

- Establish a governance and accountability structure, that has the authority to hold organisations to account, set priorities and determine responsibilities. This structure should be able to agree and delegate responsibility where gaps are identified. It should include VCS representation and resident representatives. This is about redesigning and improving the current governance, not just adding something new.
- Use the agreed minimum dataset to provide oversight and inform system level actions and strategic planning and if necessary to hold mental health services and the system overall to account

- Have shared, cross service objectives and agreements, and/or include partnership working as a core part of service design and monitoring.
- Agree who should fund and provide less clinical and more holistic elements of mental health support, as this is currently not clear or well defined.