NHS England

What does achieving parity between physical and mental health mean for you?

Why is it important to treat physical and mental health equally?

Who should you work with to achieve parity between physical and mental health?

How can you achieve parity between physical and mental health?

The NHS belongs to the people

A call to action

A CALL TO ACTION:

ACHIEVING PARITY OF ESTEEM; TRANSFORMATIVE IDEAS FOR COMMISSIONERS

Introduction

Lord Victor Adebowale

Click the image to view or visit:

http://youtu.be/h5bMHZJriZo

Introduction

Over the last 65 years, the NHS has helped deliver dramatic improvements in the health and wellbeing of the population. However, England still lags behind internationally in areas such as dementia and cancer, and there is still too much unwarranted variation in the quality of care across the country. Yet improving the existing system will not be enough; the NHS faces future challenges that together threaten its sustainability.

These challenges include: an ageing population, a significant increase in the number of people with multiple long-term conditions and mental ill health, and constrained health and social care funding as a result of the economic climate.

In July, NHS England launched **A Call to Action**, which began a programme of engagement and evidence collection that encourages everyone to contribute to the debate about the future of health and care provision in England. It also signaled the beginning of a process to develop a new strategy for the health service.

Although some aspects of this strategy will be developed nationally, at its core will be local strategies developed by commissioners and their partners. As the recently published **planning framework** sets out, commissioners and their partners have been asked to develop five-year strategic plans over the coming months, with the first two years at an operational level of detail. Where they are bold and ambitious, these plans will be an important step in implementing new and more effective care models across the health service.

To support the development of the bold and transformative strategic plans, NHS England is developing a series of discussion papers to help commissioners and their partners identify transformative ideas. These papers include **'A Call to Action: Commissioning for Prevention'** and **'Transformative Ideas for the Future NHS: A report of the NHS Futures Summit'**. These resources are intended to stimulate debate between Clinical Commissioning Groups (CCGs) and their local partners and to help them to think about changes that could be made to significantly improve the value of healthcare provision in England.

What parity means to me

'My family and I have access to services which enable us to maintain both our mental and physical wellbeing. If I become unwell I use services which assess and treat mental health disorders or conditions on a par with physical health illnesses.'[1]

Parity of esteem is defined as making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems.[2] *Source: NHS England, 'Everyone counts'.*

This publication focuses on parity between mental health and physical health. But commissioners should remember that parity could extend to dementia or learning disabilities within the wider context of health inequalities.

Introduction

This discussion paper is the third in this series of papers and focuses on valuing mental and physical health equally. It focuses on one of the outcome ambitions set out in the **strategic planning framework**: to achieve 'parity of esteem' between mental and physical health services.

The **Mandate** from the Government to NHS England instructs us to put mental health on a par with physical health, and to close the health gap between people with mental health problems and the population as a whole. But this is only our starting point: we need to go further by delivering 'parity of esteem' and commissioning services that are truly person centered in a way that addresses some of the profound inequalities of access to high quality care in England. To value physical and mental health equally is to ensure equal access to services and equal quality of those services. It requires us to address the needs of the whole person; tackling poor physical health for those with mental health problems, and treating those with physical health problems who have developed mental health disorders.

Currently physical and mental health treatments tend to be viewed, and delivered, as separate health services. This means that people with poor mental health are more likely to have poor physical health that goes untreated, or treated too late and vice versa. Additionally access to good quality mental health services has been limited.The evidence is clear: only a quarter of all those with mental illness such as depression are in treatment.[3]

These deficiencies cannot be redressed solely - or even primarily - through greater investment, although it is crucial that mental health attracts greater priority in allocation decisions. Achieving parity between mental health and physical illness will require a fundamental change to the culture of healthcare, and in the way services are commissioned and provided.

In order to meet this objective, NHS England and CCGs will need to work closely with system partners. Achieving parity of esteem is not just the role of the health and care services: it has implications for everyone in the local economy, such as local government, police, employers, and schools. Commissioners need to work outside their usual partnerships, across a fuller range of public services.

People with poor physical health are at higher risk of experiencing mental health problems.

Percentage of people affected by depression with various illnesses.[4]

Diabetes **27%**

Hypertension **29%**

Stroke **31%**

Cancer **33%**

HIV/AIDS **44%**

People who experience persistent pain are **four times more likely** to have an anxiety or depressive disorder as the general population.

Why should commissioners strive to achieve parity between physical and mental health?

Dr Martin McShane, Director for Domain 2 - Enhancing the quality of life for people with long term conditions.

Click the image to view or visit:

http://youtu.be/YAxa0GOzz9Y

Why should commissioners strive to achieve parity between physical and mental health?

"Crisis can happen at any time - two o'clock in the morning, Christmas Day - and people need help when it happens. I don't know what I would have done if crisis care hadn't been available to me when I needed it. You wouldn't say to somebody with a broken leg or a heart attack that they have to wait to see a doctor during office hours. It should be exactly the same with mental health. We really need to close this gap and start seeing mental health as important, and in need of the same amount of care, thought and urgency, as physical health."

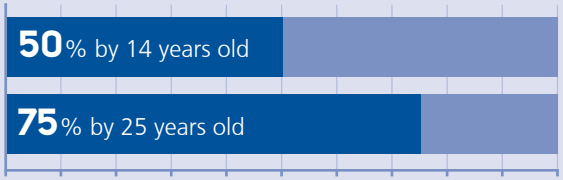
Expert by experience

Achieving parity between physical and mental health will improve health outcomes, patient experience and reduce health inequalities.

01. Mental health problems develop at a young age.

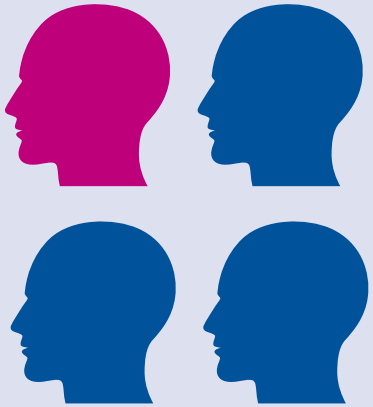
1 in 5 children have a mental health problem in any given year.[8]

First experience of mental health problems in those suffering lifetime mental health problems.[9]



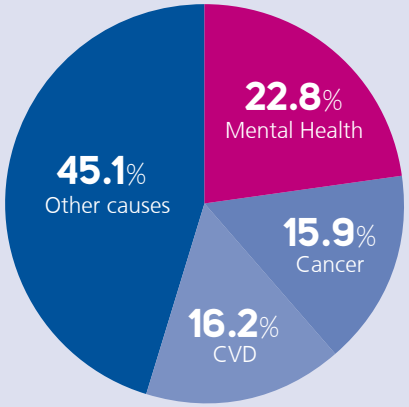
02. Mental health is widespread & common.

Every year 1 in 4 adults experience at least one mental disorder.[10]



03. Mental health is a significant burden.

Mental ill health is the single largest cause of disability in the UK.[11]



04. Mental health impacts on life expectancy.

Average life expectancy in England and Wales for people with mental health problems is 60 years behind the national average.[12]

05. People with mental health problems have worse physical outcomes.

People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases and some cancers.

PEOPLE WITH SCHIZOPHRENIA ARE:

2 x more likely to die from cardiovascular disease,

3 x more likely to die from respiratory disease.

06. When people with LTCs also have mental health issues the cost of treatment can rise significantly.

NHS BILL

1/3 people with long term physical conditions also experience mental health problems increasing treatment costs by around

£8 - 13bn a year[13]

07. The mental health of people with serious physical health problems is often overlooked.

1/2 of terminally ill or advanced cancer patients suffer from depression, anxiety, and/or an adjustment disorder...

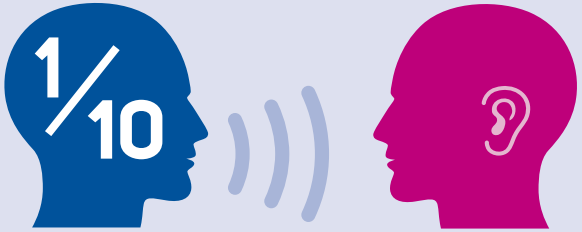
...yet less than half receive treatment for their mental health.[14]

08. Mental health problems affect the likelihood that people will be compliant with their treatment.

Depressed co-morbid patients are **three times more likely** to be non-compliant with treatment recommendations than non-depressed patients.[15]

09. There are often long waits for mental health services.

1 in 10 people wait over a year for access to talking therapies.[16]



10. There is a wider economic impact of mental health.

The full costs of mental illness in England have been estimated to be £105.2 billion a year.[17]

£105,200,000,000

What does good look like?

Michael Casells

Click the image to view or visit:

http://youtu.be/aDv5GjrWSO0

What does good look like?

As the NHS Constitution states, the NHS belongs to the people. In keeping with this principle, at a workshop in Manchester we asked members of the public, including experts by experience and carers how they would test services to ensure they were treating mental health and physical health equally. They set us the following tests:

1. Does the service fit around the individual, is it person centered?
2. Does the service reach and identify the problem early?
3. What is the impact of the service or intervention on the expert by experience and their overall health in the long term?
4. Does the service support the patient to have a voice?
5. How does this service link into other public services such as schools and the police?
6. Is the mental health element of the expert by experience's care as easy to access as the physical health service?
7. How will the service be monitored and judged as successful or not?

What these tests show is the strong emphasis that experts by experience put on coordination across mental and physical health ensuring that any problems they have are identified early on. They show the importance of working across organisational boundaries with many different parties including local government, housing services and so on. These tests also show the importance individuals place on being heard, and for 'no decision to be taken about me without me'.[18] This concept should not only be applied to decisions around treatment but also extended to decisions about how health and care services should develop in the coming years. One of the experts by experience that attended the event in Manchester **writes about his experiences** to help others understand what services should look like. Guidance for commissioners on how to engage experts by experience and members of the public in design services can be found on the **NHS England website**.

> "I found it difficult to get cohesion in my treatment and my recovery."

Michael Casells, Expert by experience

What does good look like?

Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is due to be published by the Department of Health in early 2014. This is a shared, agreed statement from all agencies involved outlining what needs to happen when people in mental health crisis need their help – in both anticipating and preventing mental health crises and in making sure effective emergency response systems are established locally.

The Concordat is arranged around four levels of mental health crisis service need:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well / preventing future crises

To support the Government's objective of Valuing Physical and Mental Health Equally, this concordat will set out ways that health commissioners, working with their partners, can ensure that people with mental health conditions get the same responsive emergency service as people needing urgent and emergency care for physical health conditions.

Case study: Co-development of the parity of esteem discussion paper

As part of the Call to Action, NHS England together with its partners held an event in Manchester with commissioners, the police service, charities, service users and members of the public to help co-develop this discussion paper. Experts and commissioners critiqued and refined case studies of best practice interventions working them up into a proposal. Members of the public, including experts by experience, developed tests through which they would assess an intervention's suitability. The experts and commissioners then pitched their intervention to the 'dragons den' of members of the public, including experts by experience, who assessed their interventions using these tests.

> "Commissioners should involve patients and carers in designing services and interventions"
>
> *Expert by experience, Manchester, November 2013*

Read about the event from the perspective of an attendee **here.**

Commissioning for parity of esteem

Professor Sue Bailey

Click the image to view or visit:

http://www.youtube.com/watch?v=Eqc6HDBXB8s

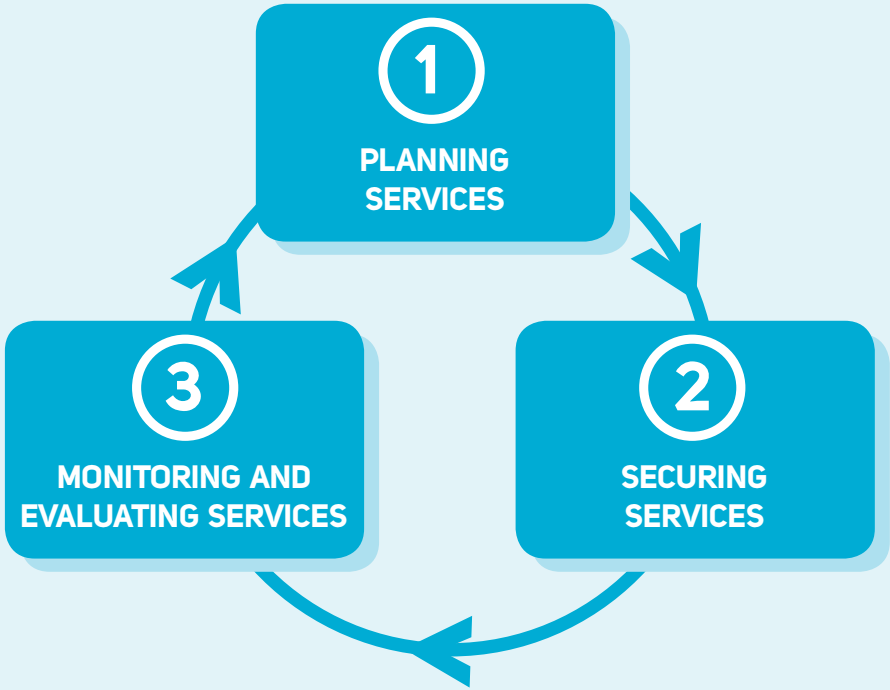
Commissioning for parity of esteem

As indicated by the expert by experience tests, putting mental health on par with physical health cannot be achieved simply with greater funding; and in any case, we know that the NHS' financial resources will be highly constrained in the coming years.

Developing a person-centered approach to care and achieving parity between mental health and physical illness requires a fundamental change in the way services are commissioned. We suggest there are three steps, in line with the commissioning cycle to achieve this, as illustrated in **Figure 1**.

Of course, different health economies may be at different stages of the process, some may have already assessed the level of mental health need and be in the midst of designing services, whilst others may still be at an early stage of the process. However, we hope that by outlining a sequence of steps that together could help realise parity of esteem commissioners will have a helpful tool for developing their five-year plans.

FIGURE 1 - THE THREE STEPS FOR DEVELOPING A PERSON CENTRED APPROACH TO CARE AND ACHIEVING PARITY



Commissioning for parity of esteem

1 Planning services

Joint Strategic Needs Assessment

In order to achieve parity between physical and mental health, commissioners should first understand the needs of their population, including their mental health needs. Working alongside Directors of Public Health and other local partners, commissioners can employ tools such as Joint Strategic Needs Assessment[19] (JSNA) to develop a nuanced understanding of population characteristics and needs. This assessment should draw on the views of experts by experience and the public as well as health professionals. Crucially, mental and physical health needs should be considered together rather than separately. From May 2014 commissioners will be able to access needs assessment and care path way profiling tools through the Mental Health Intelligence Network.

Market assessment

In addition to understanding their population's needs, commissioners should also have a good understanding of their provider market (both existing and potential), in order to understand the degree to which expert by experience needs are being met, the biggest gaps in service provision, and the main opportunities for improvement. Commissioners should understand which services are critical for system functioning and need to be protected, which services are interdependent within and across providers, and what provider model in the long term is most likely to deliver ongoing value for the patient and the taxpayer.

Setting priorities

Based on their assessment of health needs and the current pattern of provision, commissioners need to set a relatively small number of measurable priorities. Good strategies make choices because both human and financial resources are limited. Furthermore, these choices should be made together with key stakeholders including Directors of Public Health, local government, providers, experts by experience and their families, and cultural community leaders. Commissioners should catalyse the development of common goals for their local health economies, including parity of esteem.

Commissioning for parity of esteem

1 Planning services

Case study: Estimation of unmet health needs in Northampton

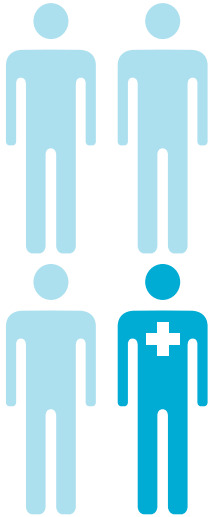
A small team working with commissioners, providers and other key stakeholders brought together a range of public mental health intelligence to estimate the level of unmet need for a population of 700,000. The work analysed:

- The level of risk and protective factors for mental health
- Estimates of prevalence based on identifying groups at higher risk of mental disorder and poor wellbeing
- Coverage and impact of current interventions
- Analysis of the size of unmet need, or the difference between estimated prevalence and the impact of current service provision
- Estimated annual cost of mental disorders

This has subsequently been translated into a JSNA and a common understanding of the impact and cost of unmet public mental health need among key local partners. Further information on how to conduct a similar assessment can be found **here.**

DEPRESSION/ANXIETY AND TREATMENT

According to the most recent Adult Psychiatric Morbidity Survey, **three quarters of people** with anxiety and/or depression were receiving no treatment at all.[20]



Commissioning for parity of esteem

2 Securing services

Designing services

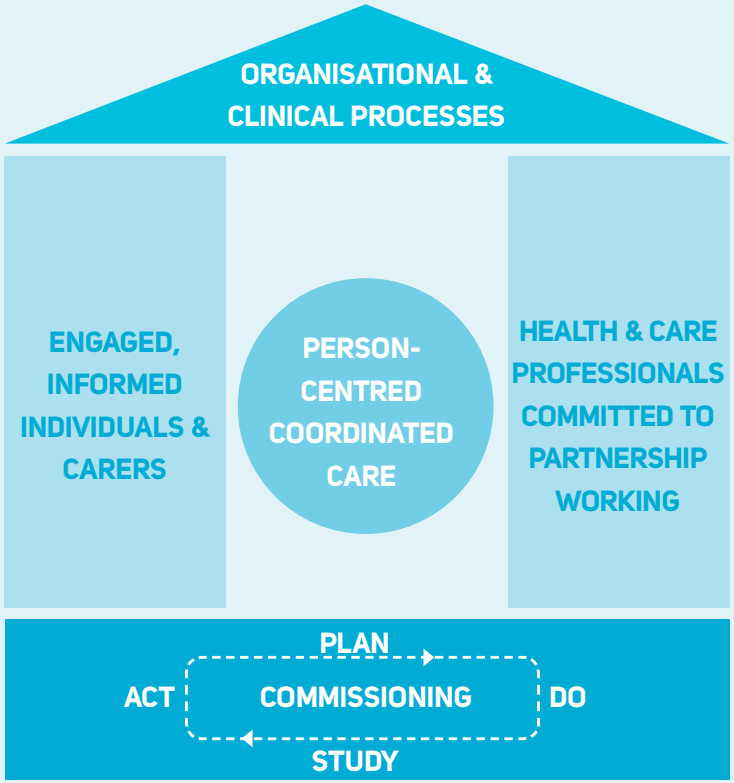
Having analysed local needs and set priorities, the next step is to design commissioning plans or service specifications that express parity of esteem. Although commissioner will have their own service design approaches, we suggest that they should be based on three key principles:

- **Integrated**, with individuals at the heart of the service
- **Co-designed** with experts by experience and carers
- Working in **partnership** across the health economy
- Based on the best **evidence**

> "We need a more holistic approach to patient treatment."
>
> *Expert by experience, Manchester, November 2013*

FIGURE 2 - THE HOUSE OF CARE

A model to plan services at national, local, and personal levels for people with long-term conditions.



Commissioning for parity of esteem

2 Securing services

Designing integrated mental and physical health services

In many cases parity between physical and mental health can be improved with small changes in service provision, such as training (physical) clinicians and other professionals in mental health screening and brief interventions. Including these changes in existing service specifications are often low cost.

However, as services are re-tendered, or new ones considered, commissioners should consider how to put individuals at the centre of commissioning decisions, and to design integrated mental and physical health services. This may involve designing an ideal pathway from first principles. Focusing on outcomes can also help: by focusing on a set of integrated mental and physical health outcomes, commissioners can incentivise the development of integrated provision.

Case study: Training of NHS practice nurses in mental health to reduce premature mortality

Dr Sheila Hardy, an Education Fellow at University College London has developed a new training programme for practice nurses. Dr Hardy and her colleagues found that people with severe mental illness (SMI) were receiving less screening for cardiovascular disease (CVD) than those with diabetes, despite people with mental illness being more likely to develop heart problems than the general population.

To address this, a course was developed to help practice nurses deliver best practice health checks for people at three pilot sites. After implementing the practice nurse training, more people with mental illness were being screened for CVD. In addition improvements were made in the number of people with SMI attending regular health checks; by implementing a designated appointment procedure – attendance rates rose back to the levels of the general population. This work has led to the commissioning of a ten module bespoke training course for practice nurses in mental health. The course covers topics such as mental health awareness, changing behavior, physical health in mental illness, medication in mental illness and care planning. The programme is funded HEE local education and training board for north central London.

More information about the UCLP practice nurse programme will be available soon at **www.bmj.com**

Commissioning for parity of esteem

2 Securing services

Co-designing services with users and carers

People suffering from mental health illness should be involved at all points of the commissioning process; this is particularly important at the design stage. Serious engagement with experts by experience and the public is about much more than consultation. The most powerful approaches include users throughout the process, co-designing services alongside professionals. For further ideas about how to fully engage patients, carers and the public in service design please see NHS England's **guidance on how to engage service users and members of the public in service design**, which includes a section on statuary duties in this regard.

> "Attending today is part of my recovery – getting involved in developing services for people like me is climbing a mountain and did more for me than any prescription I could have."

Attendee at Manchester event on parity of esteem, November 2013

Case study: Lambeth CCG

In Lambeth, faced with a dramatic reduction in resources for mental health but an increase in need, clinicians, managers and experts by experience formed a common ambition: to move from an expensive, inefficient, crisis dominated system to one focused on prevention, early intervention and enablement. All those who use the services were involved, not just as consultees but as equal partners, with clinicians, practitioners, social workers, CCG mental health leads and others in a series of workshops (with 1,600 participants in all) to redesign those services. Through this process a new expert by experience umbrella group was given formal status to contribute to commissioning.

Commissioning for parity of esteem

2 Securing services

Working in partnership

We know that many of the people who require support for mental health issues from the NHS are the same people who are interacting with other public services, such as housing or the criminal justice. This suggests there may be an opportunity to design services that build in these local partners. There may also be opportunities to design new services that span traditional boundaries between healthcare and other public services, expanding the range of services available to the population and encouraging early intervention and prevention.

> "EDUCATION ON MENTAL HEALTH IS KEY AND SHOULD BE A FUNDAMENTAL FOCUS ON INCLUDING IT IN THE SYLLABUS – SCHOOLS NEED TO BE MORE PROACTIVE WITH YOUNGER CHILDREN"

Expert by experience, Manchester, November 2013

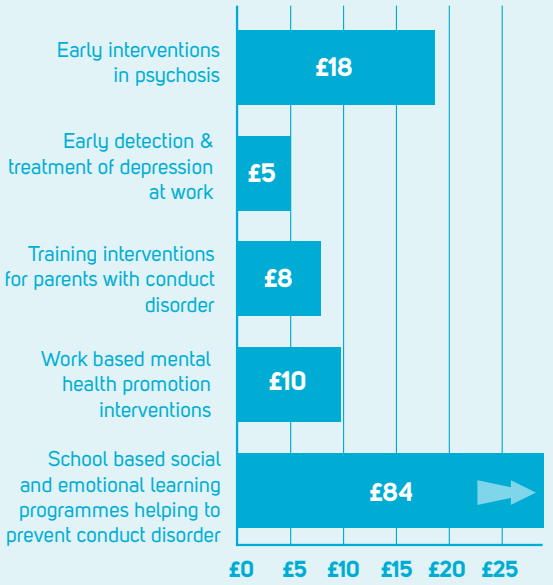
EARLY YEARS

50% of all people suffering with mental health issues experienced their first episode before the age of 14. By investing in early intervention and health promotion schemes for people with mental disorders the NHS can realise cost savings even in the short term.[21]

Figure 3 (right) indicates the average net return against each pound invested in that area of care and/or training.

Figure 3 also highlights the important role that local partners (e.g schools and employers) have to play in supporting good mental health and wellbeing. For example, where school nurses have training in mental health awareness, educational, individual and family gains can be significant.[22]

FIGURE 3 - THE AVERAGE NET RETURN AGAINST EACH POUND INVESTED IN THAT AREA OF CARE AND/OR TRAINING.



Commissioning for parity of esteem

2 Securing services

As well as your local health and care partners, commissioners should also consider working with partners outside of the public sector, such as employers. 1 in 6 people in work suffer with mental health conditions suffering with mental health conditions are of working age.[23] There is strong evidence to suggest that stressful employment, loss of employment and the risk of unemployment are associated with an increased rate of harmful stress, anxiety, depression and psychotic disorders. In this regard commissioners share a common objective with employers; to keeping the workforce healthy and well.

Working together with a wider set of stakeholders in designing integrated physical and mental health services could leverage additional financing and capacity to achieve mutually beneficial outcomes.

Case study: BT's Work Fit programme

"When a person becomes unemployed his welfare falls for two reasons – first the loss of income, and second the loss of self-respect and sense of significance" Richard Layard.

Evidence suggests that being in paid work is one of the most important factors in achieving recovery from mental ill health; supporting people with severe or enduring mental health problems to gain or stay in employment improves their prognosis significantly.[24] There is therefore a strong case for government and employers alike to promote parity of esteem.

To support their employees' mental and physical health, BT has developed a 'Work Fit' programme with three aspects:

- **Primary intervention:** seeking to promote good mental health and prevent ill health by promoting physical activity and healthy eating, providing break areas and good facilities as well as education and training in mental health;
- **Secondary intervention:** a continual process of maximising support, building resilience and enhancing coping, identifying and addressing issues early and action planning; and,
- **Tertiary intervention:** stepped-care suite of proportionate interventions for identified mental health problems and well-being issues.

BT's approach has produced significant results. The sickness absence rate due to mental health problems fell by 30% in four years despite pressured market conditions. Further, almost 80% of people off for more than six months with mental illness were brought back into their own jobs versus 30% five years previously and about 20% nationally.[25]

Commissioning for parity of esteem

2 Securing services

Allocating resources and contracting

We expect the total envelope of resources to remain flat in real terms over the coming years. This will inevitably constrain the resources commissioners have at their disposal to develop services that address patients' physical and mental health needs. Some changes can be made that will have little or no effect on net expenditure however; commissioning fully integrated services may require investment. The five-year planning process gives commissioners the platform to re-allocate resources away from less productive or lower priority activities. We know there is wide variation in what different areas expend on the same 'programme budget' or health problem, even after the data is standardised for age, sex, and deprivation. For instance, in the financial year 2008/09 - 2009/10 the amount spent by different Primary Care Trusts on cancer inpatients varied nearly 2.5 times (weighted for age, sex and need) across England.[26] This suggests there is considerable scope for reallocating resources without reducing quality or outcomes. The recently produced **Commissioning for Value** packs will assist CCGs to identify in which programme budget areas they are outliers compared to CCGs with similar populations and deprivation.

Commissioners will also want to consider how they can leverage the full range of resources to fund prevention priorities. The **Better Care Fund** creates a pooled budget that can be deployed with the agreement of Health and Wellbeing Boards to invest in parity of esteem. However, it is also likely that existing budgets controlled by other local partners could be deployed more effectively - be they schools, local government, employers or health and care providers. To facilitate this collaboration, commissioners may wish to consider contracting approaches that enable risk and resource sharing.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

Improving Access to Psychological Therapies is a NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders.

The programme was created to offer people suffering from mental health illness a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. The programme was first targeted at people of working age but in 2010 was opened to adults of all ages.

Evidence shows this approach can save the NHS up to £272million and the wider public sector will benefit by more than £700 million.[27]

Commissioning for parity of esteem

2 Securing services

Potential contracting approaches

The key to achieving parity between physical and mental health is to design patient-centric services that is, where services are integrated and 'wrap around' the service user no matter whether their needs are physical, mental or social. Once integrated services have been designed and outcome-focused specifications developed, the next step is to find a contracting vehicle that incentivises integration amongst different providers and holds them to account for the right things. There are several approaches commissioners could take, and no one size will fit all, in some cases you many need to innovate within existing contracting arrangements. However, here are a few approaches to consider:

Prime contractor model. On this approach, commissioners contract with a single provider (the prime contractor). This prime contractor is responsible for the delivery of the entire service, and for the co-ordination of its supply chain, entering into sub-contracts with other providers as required. This approach allocates the risk and costs of coordination between services to the prime contractor rather than the commissioner.

Integrated pathway hub (IPH). This vehicle allows commissioners to enter into separate contracts with a number of providers, all of whom contribute towards the delivery of an integrated service. Risks and rewards are allocated between the commissioner and the provider under each contract. One of the providers, the IPH provider assumes responsibility for the co-ordination and management of the integrated service and is appropriately compensated for this integration and management function.

Alliance contracting. Typically, an alliance contract will bring together a number of separate providers under a single contract. Key characteristics of alliance contracting are said to be alignment of objectives and incentives amongst providers; sharing of risks; success being judged on the performance of all, with collective accountability; contracting for outcomes; and an expectation of innovation. This approach differs from IPH, in which each of the providers has a separate contract with the commissioner. In alliance contracting there is only one contract.

Both the prime provider and the IPH models can be used with the NHS Standard Contract, the provisions in the Contract around sub-contracting for 2014/15 have been specifically strengthened, so that they better support these models. Some forms of alliance contracting are not currently compatible with the NHS Standard Contract, specifically where multiple providers are signatories to a single commissioning contract. However the key characteristics of alliance contracting can be accommodated in a structure involving one or more NHS Standard Contracts.

Any commissioners who are keen to discuss an alliance contracting approach as a mechanism to achieving POE are encouraged to contact the NHS Standard Contract Team via **nhscb.contractshelp@nhs.net.**

Commissioning for parity of esteem

3 Monitoring and evaluating services

Evaluation should be thought through before services are commissioned. Crucially, outcomes must be clear and concrete enough to be measured regularly over time. This may require a mix using a mix of short-term (process) and longer-term metrics, including cost-effectiveness metrics. These should include measures of user experience as well as the application of user tests like those outlined in section 3 of this document. Rapid and continual assessment is key to ensuring that success can be evaluated quickly enough to adapt programmes where they are not working – or scrap them in favour of more effective alternatives. You should also consider carefully who you use to carry out the evaluation process, getting the balance of objectivity but also building in your key partners. Importantly, people suffering from mental health illness and carers should be supported so that they can be directly involved in the evaluation process.

> "We have to be able to measure what we do in a very simple way, and one that means something to the public, the Treasury and to the users and carers themselves."
>
> *Professor Sue Bailey*

Conclusion

Dr Geraldine Strathdee

Click the image to view or visit:

http://youtu.be/-yYPFUQ5EiE

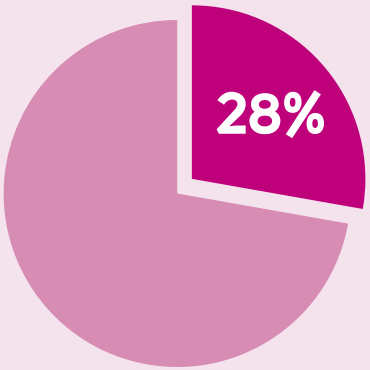
Conclusion

The NHS needs to change fundamentally to meet the challenges of the future. Putting mental health on a par with physical health is an ambition that would transform the health service, enabling it to address the widespread prevalence of mental health disorders and the unacceptable inequalities experienced by those with mental illness.

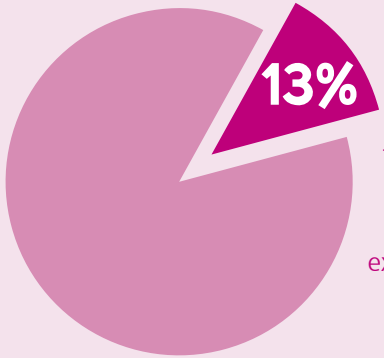
Achieving this change will be very challenging given the financial constraints under which the NHS must operate in the coming years. It requires an honest assessment of the extent to which parity is currently being achieved, and the prioritisation of service change to address the gaps. Addressing these gaps is likely to call for a new approach to commissioning that focuses on outcomes, co-designs services integrated around the user, employs innovative contracting techniques to incentivise provider integration, and evaluates continuously. As part of this process consideration of re-allocation of resources to improve parity between physical and mental health will be key. The five-year plans that commissioners will lead in the coming months provide the platform for making the ambition of parity of esteem a reality.

> "WE NEED TO REDUCE THE MORTALITY GAP BETWEEN THOSE WITH MENTAL HEALTH ISSUES AND THOSE WITHOUT."
>
> *Expert by experience, Manchester, November 2013*

MENTAL HEALTH VS PHYSICAL HEALTH



Mental health problems account for **28%** of morbidity...



...but receive only **13%** of NHS expenditure.[28]

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