GREATER LONDON AUTHORITY
Health & Communities

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Victoria Borwick AM
Chair, Health and Public Services Committee
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Date: 22 February 2012

Dear Victoria,

Mental Health and the London Health Improvement Board

Thank you for your letter following the meeting of the Health and Public Services Committee on 13 December, 2011. I would very much like to commend the Committee for taking the time to explore the issues and needs surrounding mental health, particularly at a time in which physical health services and the changes to the NHS occupy so much of the public discussion.

Mental health was one of nine priorities originally considered during the project proposal stage for the initial work of the London Health Improvement Board. The board's decisions at this stage were based on a review of the 32 boroughs' Joint Strategic Needs Assessments and consideration of the following criteria, which should apply in determining issues where delivery at pan-London level provides added value or benefit:

- It is an important health improvement issue for London
- The partnership of the Mayor/London Councils/NHS provides a unique contribution to improvement
- There is evidence that action could be effective if delivered at the city level as opposed to the local or supra-local levels
- There is enthusiasm and support from leaders, elected members and senior officers.
- It is an issue that affects the whole population
- It is an issue where practical and realistic action is possible
- It is an issue that maximises the opportunity created by the 2012 Olympic legacy
- It is an issue with capacity to engage other partners
- It is an issue where all founding partners can contribute significantly.

As you know, it has been decided that the initial priorities for the LHIB are alcohol abuse, childhood obesity, the prevention and early diagnosis of cancers, and information transparency and integration. While mental health was strongly considered, it was felt that the board was in better position to tackle these health issues initially.

While I agree with you that the LHIB should account in these priorities for the strong connection between physical and mental health, I would expect that the board not be the only organisational body addressing this connection nor the entity to lead on it. Local Authorities are the principal public health budget holders, from whom the LHIB will receive a 3% funding top slice; and Health and wellbeing boards are designed to be a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch to discuss how to work together to better the health and wellbeing outcomes of the people in their area. Such structures are more suitably placed to lead on developing joint working between mental and physical health services.

This is not to say that the LHIB is failing to address the connection between physical and mental health. It is worth noting that the King's Fund and the Centre for Mental Health this month jointly published *Long-term Conditions and Mental Health: The cost of Co-Morbidities* to draw attention to this connection and the effect it has on care and recovery. In the report, the authors developed four recommendations for improving the care of people with co-morbid mental and physical conditions. They stated that care could be improved by:

- integrating mental health support with primary care and chronic disease management programmes
- improving the provision of liaison psychiatry services in acute hospitals
- providing health professionals of all kinds with basic mental health knowledge and skills
- removing policy barriers to integration, for example, through redesign of payment mechanisms.

The information transparency and integration workstream of the LHIB is beginning to explore these issues of services integration and looking at opportunities to improve the connection between physical and mental health. One of the workstream's three priorities is to facilitate professionals in health and social care (clinicians, commissioners, managers, academics, policy makers) to have access to integrated service information. This will assist clinicians in delivering better and more concerted multidisciplinary care, and enable commissioners and policy makers to make effective use of data to improve population health.

This work in data integration, however, is not the only way in which mental health is being addressed in the LHIB workstreams. Determinants of health have a cumulative effect across the life-course, and factors in one domain, if not addressed, can have a significant positive or negative impact on another. That is why, although mental health was not included in the LHIB's initial set of priorities, we have sought to include it in our alcohol abuse and childhood obesity workstreams as part of a comprehensive, whole-systems approach to addressing these health issues.

In the alcohol workstream, the LHIB is working to increase the number of Identification and Brief Advice sessions offered according to NICE standards in acute, primary care, pharmacy and mental health settings by 20%. By increasing these interventions in mental health settings, we will increase the identification and addressing of co-morbid conditions and individuals who self-medicate a mental illness with substance abuse. We are also working to improve licensing laws in order to tackle underage drinking.

In the LHIB's work on childhood obesity, the Board is developing the London Obesity Framework to provide the long-term strategic and practical support to enable London to achieve a sustained downward trend in levels of excess weight. We are currently working with stakeholders across London to develop this framework around the aforementioned whole-systems approach that sees

obesity as the result of a complex system rather than a set of separate, simple problems. It is our goal to develop a framework that will harness the commitment of all parties; and stimulate action firmly based on the best available evidence.

It is in this context that we will ensure our work takes account of mental health issues, along with the many other factors that relate to obesity. Through this methodical, consultative approach, we can ensure that action to tackle obesity is targeted at those most at risk, and takes every opportunity to promote the wider health of London's children.

Going forward, it is our intention to continue addressing the priorities of the LHIB in a comprehensive, holistic way that accounts for the causes of the causes of disease. As such, mental ill health and the determinants that affect it will continue to be considered in everything we do. It will also continue to be a proposed and considered issue as further priorities for the board are identified according to the criteria for prioritisation and by agreement of Board members.

With regard to the final point in your letter, that the LHIB consider a mental health promotion and prevention workstream focusing on children and young people, I have already covered how priorities for the LHIB will be chosen in the future. I would agree with you, though, regarding the importance of addressing children and young people's mental health needs. 50% of lifetime mental illness begins by the age of 14, so addressing mental illness in a timely fashion will, by necessity, entail a greater focus on children.

That is why, although the Mayor is not responsible for health care services or the decisions of the NHS, I recently wrote to Ruth Carnell, Chief Executive NHS London, reiterating the Mayor's desire to see an improvement in the emotional health and wellbeing for young people in care and promoting the inclusion of mental health in the NHS Operating Framework. We hope to explore opportunities for working in partnership with NHS London on this very important issue.

Yours sincerely

Pamela Chesters
Mayoral Advisor on Health and Families