Draft Proposal paper for Greg Barnes, (Practice Manager of Wish Park Surgery) and cluster 4 and 6 leads. 16. 1.19

Proposal for a pilot Community Care Centre on first floor of 191 Portland Rd Hove to end the Prozac city.

of John Kapp of SECTCo (22, Saxon Rd Hove, 01273 47997 johnkapp@btinternet.com Papers thus (9.91) refer to those on section 9 of www.regionaldkapp.org .

1 Summary of this proposal

a) **The problem of drugs**. This project is an attempt to reverse the epidemic of depression caused by the drugs prescribed to cure it, known as the 'Prozac nation'. In 2006, 2.5 million patients were on antidepressants (ADs) and 1 million were addicted to them, so the government tried to end the 'Prozac nation' by launching the Improving Access to Psychological Therapies (IAPT) programme. Now 7.3 m, (13%, or 1 in 8 of the population of England - 56m) is on them, and 4 million are addicted, and the number is increasing at 8%pa. Unless something is done to prevent this iatrogenic (doctor-induced) disaster (as this project seeks to do) in 3 years time, by 2021/22, 10 million patients (18%, or 1 in 6) will be on them, of whom 6 million will be hooked. These drugs are palliative, but don't even claim to be a cure. They have side effects which are worse than the disease, including suicidal and homicidal thoughts. This service does more harm than good because patients who go to their doctor for 'low mood' come away with a 'long term condition' which has to be 'managed with ADs for the rest of their wrecked lives. In the city of Brighton and Hove (population 300,000, which is 1/200 of England) 50,000 are now on AD prescription, of which 30,000 are hooked.

b) **The problem of IAPT**. The IAPT service treats about 500,000 patients annually, and claims a 50% recovery rate. Its main intervention is Cognitive Behavioural Therapy (CBT) offered one to one for about 6 weekly session of 50 minutes. It is far better than ADs, but is only effective in about 1 in 10 patients. Furthermore, it is subject to assessment as a secondary care service, and the Referral to Treatment (RTT) waiting time is 6-9 months, so it cannot be regarded as an effective mental health service. This is why GPs prescribe ADs to 15 times more patients (mostly against NICE guidelines), than to IAPT and Wellbeing services. Furthermore, the staff employed under a system of block performance contracts which dis-incentivise healing (9.88) as they are paid the same whether the patient attends or not.

c) **The solution of Community Care Centres**. As rightly stated in the government's 10 year plan, (announced 7.1.19) the NHS should prevent ill health (which means stopping prescribing ADs) and investing in what is called: 'social prescribing for population health' (see appendix 1) The Better Care Fund (BCF) legislation 2013 not only called for 'better care' (drug-free), but also provided new money to pay for it. BCF now (2018/19) allocates £28 mpa locally, (£5.8 bnpa nationally) to treat vulnerable patients, personified as Rachel (65, depressed and in sheltered accommodation) and Dave (40, alcoholic and homeless) in Community Care Centres (CCCs) as mental A&Es, open 24/7, but to date no CCC has yet been built in the city, so no Rachel or Dave has yet been treated. This project would rectify this omission.(9.125)

d) **A pilot CCC at 191 Portland Rd** This paper proposes to trial a drug-free mental health service and crisis centre for West Hove, including detoxification and rehabilitation with the aim of ending Prozac (AD) dependence in West Hove. It would provide a CCC above Wish Park surgery at 191 Portland Rd, Hove, which is well served by public transport. Its 290 square m would include a reception area for patients at the ground floor entrance, 4 group therapy rooms for up to 25 patients, an open plan administrative office for 20 staff, refreshment area, 3 beds for staff and 3 for emergency crisis patients. Socially prescribed complementary services would be provided under a negotiated licence agreement contract with local providers (henceforward called 'the Provider') led by the authors of this report, John Kapp and Denise Millar. It would treat up to 1,000 vulnerable patients annually with up to 75 hours of varied complementary therapy of their choice over 10 weeks, free at the point of use, on doctor referral from clusters 4 and 6 surgeries, and self referral. Surgeries referring would include Wish Park, Links Rd, Benfield Valley, Hove Medical Centre, Mile Oak, Portslade Health Centre. The Provider would staff it with about 30 complementary therapists and administrative staffed from the local private sector. Other local venues would be used as outreach, including Change gym, Portland business park, (about 800 m west) at www.changehove.com,, Tree of Life, 143-145 Portland

Rd (about 200 m east)(www.tolcentre,com) and Essence, 86, Church Rd Hove, (about 1,200 m east) www.essencehove.com, and other venues in Hove.

e) **Master plan for 20 CCCs in the city.** This pilot CCC would be the first of 20 in the city by 2022/23, under a Clinical Commissioning Group (CCG) master plan to implement the intention of the BCF, and new NHS 10 year plan. Each CCC would be budgeted to cost around £1 mpa. Assuming that this pilot project is successful, similar CCCs would be established at yearly intervals as follows. From summer 2020, 4 similar CCCs for patients in clusters 1,2,3 and 5. From summer 2021, another 5 CCCs would be created to double capacity, to make 10 in total. From 2022/23 an additional 10 CCCs would double the number of CCCs to total 20. They would cost the CCG £20 mpa, and provide treatment to help 20,000 patients annually to withdraw from addiction, (including ADs) which is not available on the NHS at the moment. This project would give new hope to GPs and staff of surgeries, and reverse the crisis of recruitment and retention. It would end the title 'Prozac' city of Brighton and Hove, and be a beacon for the rest of the country to follow.

2. How would the £1 mpa for this project be raised?

This proposal assumes a budget of about £1 mpa, paid to a Provider (hopefully SECTCo and SAGE) under a licence granted under a service level agreement. The contract would be 'output' (rather than 'performance block' based), on 'payment by results' (rather than 'fixed price') so the NHS and taxpayers would only pay for treatments actually received by patients (unlike the present 'block ' contracts by which clinicians are paid the same whether patients attend or not. Payments would be by tariffs for up to 75 hours of facilitation over 10 week periods, comprising salaries of about £900,000 for about 30 full time equivalent staff facilitating interventions, and administrators, who would get average salaries of £30,000 pa or 1.5 times minimum living wage. The project would also employ an equal number of volunteers, who would not be paid for their services. We estimate about £100,000 to cover rent, rates and services. This proposal integrates the following funding intentions of the government:

a) The CCGs Locally Commissioned Services (LCS) budget of £2 mpa, which goes to the 6 clusters annually. It has not all been taken up in previous years. It is the preferred way to fund this project.

b) If not LCS, the above mentioned BCF of £28 mpa 2018/19, which I have been told has been fully allocated this year, but hopefully, £1 mpa could be made available from next years allocation of £30 mpa for 2019/20.

c) Ultimately, CCCs should be funded by Brighton and Hove's share of the 10 years plan (launched on 7.1.19, promising an extra £20.5 bnpa nationally from 2022/23 of which our city could get £100 mpa more (on top of the CCGs probable £500 mpa, totalling £600 mpa) for prevention and treatment of mental sickness in the community under social prescribing to keep them out of hospital, and improve population health (see appendices 1 and 2). This project meets all the 10 year plan's objectives.

3 Who has written this report?

This report has been written by John Kapp on behalf of a partnership of the lead therapists of SECTCo and SAGE. John Kapp (born 1935) followed his father into consulting engineering, and has now integrated his work with that of his mother, who was a Freudian psychiatrist. He suffered a breakdown of his physical health in 1991, and discovered the benefits of Complementary and Alternative Medicine (CAM) He joined the Foundation for Integrated Medicine (FIM, which later changed its name to FIHealth) He nursed his late wife, Janet, through cancer, taking her to the Bristol Cancer Help Centre (now Penny Brohn) After she died in 2000 he bought 86 Church Rd Hove to 'bring Bristol to Hove', and with his second wife (Phoebe Wyss) created 'Planet Janet' in 2002. In 2003 he let the business on a 20 year lease to tenants Richard and Clare Brown, who rebranded it 'Revitalise'. In 2016 they assigned it to Robert Hodgetts and Vanessa Hindle, who rebranded it 'Essence'. Following a vision of integrating CAM into the NHS, in 2010 he formed SECTCo (Social Enterprise Complementary Therapy Company) see www.sectco.org.uk. He did the facilitator training, and developed a NICE recommended Mindfulness Based Cognitive Therapy (MBCT) 10 week course for SECTCo. (9.91). To date it has run 41 courses to over 300 starters, of which 209 finished. John also trained from 2004-8 in family constellation group therapy, and since 2008 has been running these groups every week, totalling over 1,000 hours. He was given a free shop at 3, Boundary Rd from 2012-15, which treated thousands of vulnerable clients for donations or free, in his Community Care Centre (see pictures and text on 9.112). His campaigning papers can be

seen on section 9 of www.regionaldkpp.org, which describe the interventions that this project would provide, and the way that the therapists and administrators would be paid for their services.

Denise Millar formed SAGE Holistic, comprising a partnership of 13 complementary therapists in Hove. It has treated ….. clients to date in Hangleton at subsidized rates, according to their ability to pay. It was recently awarded a grant of £……. to treat 10 patients with various long term conditions for 2 months pilot trial, the results of which are being written up, and are available on request. If contracted under this proposed CCC, It offers a full range of complementary therapies to patients on GP referral, at terms proposed below.

4 The empty space above Wish Park surgery at 191, Portland Rd, henceforward called 'the Premises'

Wish Park surgery used to be at 124, New Church Rd (opposite Wish Park) but moved in August 2015 to the architect designed ground floor of a block of flats at 191, Portland Rd Hove. It is well served by public transport, being about 1,000m east of Portslade rail station, 400 m west of Aldrington rail station, and buses numbers 2, 46, and 49 stop outside the surgery door. Light touch parking applies throughout the local area, restricted at 10-11am, and 6-7pm. There are Sheffield cycle stands on the pavement outside, but we would provide 50 extra cycle parking bays, preferably of the type that are outside rail stations. This would encourage patients to cycle for exercise.

The surgery now has over 7,000 patients, and aspires to increase this to 10,000. When the building was planned, the practice envisaged needing extra space, which Affinity Sutton provided on the first floor, designated D1 planning for health related purposes. However, this space has been empty for nearly 4 years. It measures about 22m X 15m, with some obstructions in the corners for stairs and the lift, but totals 290 square m of usable space. It is still in 'shell and core' state, with services capped off. I estimate that it would take about £200,000 to furnish it with partitions, toilets, and furniture and fittings ready to take patients, which would take 3 months to fit out. We are seeking partners to provide this. The owner of the block is Affinity Sutton, who have recently rebranded as Clarity. The rent asked is £16 per square foot, which would be about £48,000 pa, but the agent (Ed Deslandes of Fludes) says that they would allow a rent free period for fitting out. The following photos were taken on 9.1.19,

View outside the Premises, looking East, along Portland Rd. The front door is the first door on the right. The corner room on the ground floor is called the 'lobby' and is about 15X5 m, totalling 70 square metres, which gives access to the stairs and lift to the first floor. It is being offered as an integral part of the tenancy agreement, and we proposed to fit it out as an office and reception area for patients.

The space offered is the whole of the first floor of this western end, which is faced with red bricks, and has generous windows on the west and south faces.

This is the internal view looking north

this is the view looking south and west.

5 What are the principles of the socially prescribed treatment interventions to be provided under this service?

a) This Community Care Centre (CCC) shall be a primary care mental A&E and crisis centre, open 24/7 and 365 days pa to which anyone can self refer, and shall give immediate support to all who attend, signposting as appropriate to other services.

b) Its interventions shall all be provided in groups of patients, to provide opportunities for social interaction between them, thereby countering social isolation.

c) The groups shall aim to be between 5 and 15 patients, and run weekly for 1-3 hours per session.

d) Every group shall be run by a facilitator, supported by a deputy facilitator, (who can be a volunteer trainee) whose responsibility is to look after any member of the group who needs additional support.

e) Interventions that are usually taught one to one (such as massage, counselling, psychotherapy, acupuncture, brain spotting shall be taught by them working on each other, in pairs, under supervision.

f) The groups shall disband after 10 weeks (2 months) but patients can repeat the group by getting a repeat prescription, or by self referral by registering with the receptionist.

a) Patients shall be assumed to know best what interventions and groups they need, so shall have the right to choose what they book for, and change groups when they wish, by registering that change with the receptionist.

6 What interventions are intended to be provided by the service?

b) Exercise classes, both inside the centre, and outside, such as walking groups, group jogging, group swimming in the sea and King Alfred (perhaps from changing rooms at the Deep Sea Anglers Club, by the lagoon, 1.200 m away) military fitness programmes, and other similar exercise activities.

c) Meditation classes for 1 or 2 hours, such as dynamic, kundalini, natarage (dancing) nadabrahma (humming) mindfulness, (vipassana) holotropic breathing, flushing, AUM, 'Who is in?', mystic rose, etc

d) NICE recommended Mindfulness Base Cognitive Therapy (MBCT) 10 week classes of 2.5 hours per day for 10 weeks.

e) Psycho-education courses, including family constellation, Buteyko breathing, bereavement, self harm, suicide.

f) Self help groups for addiction, men, women,

7 How this scheme would work by negotiating a licence agreement between the Provider and the Commissioner

a) The Provider leads (John Kapp, Denise Millar at the moment) would convene a prospective **provider steering group** (PPSG) to prepare a business case for the Provider to put to:

b) The Commissioner leads, who would form a prospective **commissioner steering group** (PPCG) of representatives of cluster 4 and 6 surgeries such as Rick Jones, cluster 4 lead, Steve Cribb, federation lead, Greg Barnes, practice manager of Wish Park, Chris Clark (director of commissioning of the CCG) Adam Doyle (CEO, CCG).

c) The Provider would be granted a licence to provide the service in the form of a course, according to the terms, which could aim that annually 1,000 vulnerable patients would be treated with up to 75 hours of the interventions for 1 day per week for 10 weeks, at a tariff rate of £1,000 per satisfied patient completing the course of treatment.

d) The Provider would provide up- to 1,000 patients annually with such courses at the Premises, which would be the first floor of 191 Portland Rd, augmented by such additional venues in West Hove as agreed from time to time by both parties.

e) Patients from the surgeries in the scheme would be referred by their doctor to these interventions by voucher **prescription** (on the lines of appendix 2 of 9.116) which prescribes a mindfulness plus 10 week course for 1 day per week for 10 weeks, at a tariff price of £1,000 per satisfied patient who completes the course.

f) Other courses as agreed by both parties would also be provided as required.

g) The patient would take the prescription to the Provider's receptionist in the entrance lobby, who would book them in to the next available course. The patient would attend the sessions, and at the end of the 10 week course sign the prescription that they were satisfied with it, and give it to the receptionist.

h) The Provider would send all the signed prescription forms to the CCG monthly in arrears with an invoice to pay for them at the tariff rate, and the CCG would pay the provider monthly in arrears.

i) The Provider would pay the therapists and administrators a salary with bonuses according to their performance in satisfying the patients, thus ensuring the high quality of the service provided, as they would not get paid for unsatisfied patients.

j) The Provider would work by 'Open book' accounting, to protect the taxpayer.

8 Furnishing and fitting out of the Premises

We estimate that about £200,000 is needed to fit out the Premises to the appropriate standard, which would take about 3 months. A previous enquirer to Fludes (Les Fisher of www.hovetherapyrooms.co.uk) has made plans to furnish the space for about 10 individual therapy rooms, but has withdrawn. I have invited him to join our partnership to take this project forward.

9 Has what you are proposing been provided elsewhere in England?

I have not yet heard of any Community Care Centre being provided on the lines of the above project, but there are many examples available of the provision of many of the individual interventions, as follows.

a) Free psycho-education courses on self referral have been provided at scale in Swindon's primary care service since 1993, making them the quickest and cheapest Referral to Treatment (RTT) mental health service in England (9.63) This service was been extended to Avon and South Gloucestershire from around 2013.

b) Social prescribing has been provided at Bromley by Bow, London NHS surgery for around 30 years (Campaign for Social Prescribing on www.sectco.org.uk)

c) Social prescribing has been provided at Brighton Health and Wellbeing Centre, 18-19, Western Rd Hove, BN3 since 2013, (www.brightonhealthandwellbeingcentre.co.uk) which provides some of the above interventions, and subsidizes them from its charity, so that it is low cost or free at the point of use. This is the only practice in the city that does not have a recruitment and retention problem, and has a healthy energy that can be felt by anyone on entering their rooms.

d) The Horizon project provides free complementary therapy to NHS cancer patients at Royal Sussex County Brighton. However, the therapists do not get paid by the NHS to provide the service, so it has a long waiting time, as few therapists can afford to work voluntarily.

10 Conclusions

There are 100,000 vacancies in the NHS because nobody wants to work in the toxic environment where the only treatment is drugs. The present mental health service of ever increasing (at 8%pa compound) antidepressant prescribing is not only ***not fit for purpose***, but is ***doing more harm than good*** by ***creating*** the Prozac nation that we taxpayers are paying doctors to ***treat***. AD is a ***fake treatment***, which converts low mood into long term depression and dependency (addiction) like alcohol and tobacco, but at our expense. It has already harmed 4 ***million of our citizens*** by getting them addicted, without their consent, betraying their trust, and at taxpayers' expense. Furthermore, this archaic system is crippling primary care by forcing GPs to break their Hippocratic oath 'do no harm', causing them to feel guilty and ashamed, burn out and retire early at an average age of 55.

This project to create a Community Care Centre offering free complementary therapy in Hove is a start to halt and reverse this iatrogenic (doctor-induced) harmful system. Its innovation is giving ***social prescribing*** the same status as ***medication prescribing***, and ***complementary therapists*** the same career prospects as ***NHS health professionals***, by recruiting them to treat patients as if they were paying clients, and paying them the market rate for their services, as is commonplace in Denmark, Germany, Switzerland.

This project could transform the health of a thousand vulnerable patients annually in Hove, at a cost of £1 mpa, but saving society £10 mpa in these vulnerable patients' reduced attendance at GP surgeries, A&E, hospital admissions, rehousing costs, unemployment costs, and brushes with the police and criminal justice system. Furthermore it would rejuvenate primary care by empowering GPs to rediscover what they came into their profession to do, namely heal, by prescribing social treatments that work for patients, ensuring recruitment and retention of staff.

11 Recommendations – actions required for this scheme to proceed

a) The prospective provider should form a steering group to negotiate on these draft terms. Action John

b) The prospective commissioner should form a steering group to negotiate on these draft terms. Action Greg

c) Representatives of both should meet and negotiate an agreement Action John and Greg.

I would be pleased to hear from anyone interested in joining the provider steering group, and look forward to hearing your comments and suggestions.

Appendix 1 Population health (from Kingsfund, www.kingsfund.org.uk)

A framework for action: the four pillars of population health Dec 2018

Our vision for population health is based on the four interconnecting pillars in Figure 2.

- There is now a wealth of evidence that the **wider determinants of health** are the most important driver of health. In addition to income and wealth, these determinants include education, housing, transport and leisure.
- **Our health behaviours and lifestyles** are the second most important driver of health. They include smoking, alcohol consumption, diet and exercise. For example, while reductions in smoking have been a key factor in rising life expectancy since the 1950s, obesity rates have increased and now pose a significant threat to health outcomes.
- There is now increasing recognition of the key role that **places and communities** play in our health. For example, our local environment is an important influence on our health behaviours, while there is strong evidence of the impact of social relationships and community networks, including on mental health.
- Recent years have seen a strong focus on developing an **integrated health and care system**. This reflects the growing number of patients with multiple long-term conditions and the need to integrate health and care services around their needs rather than within organisational silos.

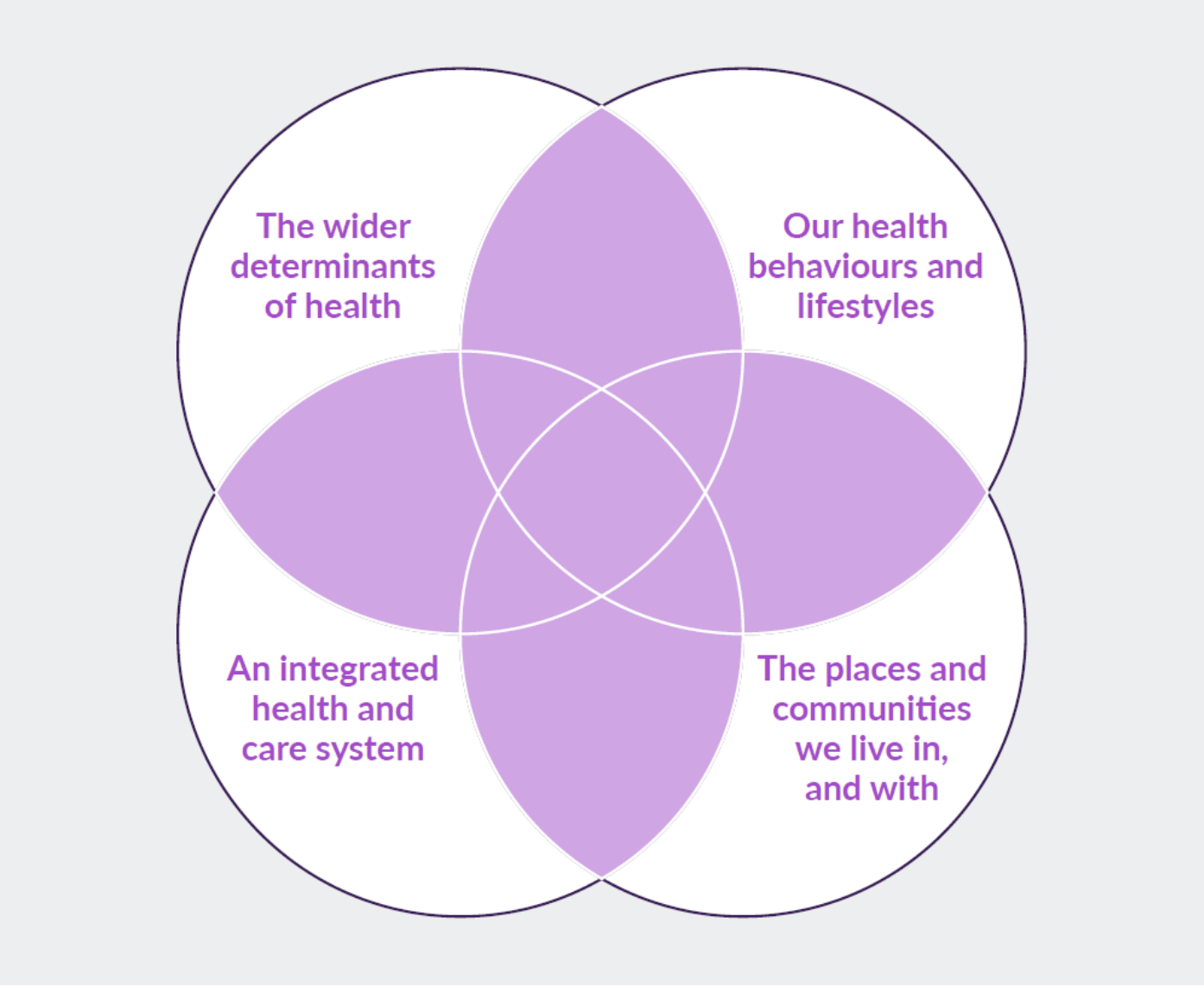

Figure 2: a population health system

Together, the four pillars form the basis for a **population health system**. As a concept, this is not new. However, current efforts in relation to the pillars are not in balance and there is not enough focus on the pillars as interconnecting parts of the same system. A more balanced approach is required that distributes effort across all four pillars and, crucially, makes the connections between them.

1. Population health management uses data to plan and deliver care to achieve maximum impact on the health of a population.

What needs to change?

Achieving our vision and delivering improvements in population health will require concerted action at national, regional and local levels, drawing on the assets of people and communities. Improving population health is a shared responsibility and progress also depends on supporting people to live healthier lives. We recommend change in three main areas.

Leadership

Strong political leadership is essential to ensure that improving population health is a key priority for the health and care system and across government. In reducing health inequalities, lessons can be learnt from the progress made under the last Labour government. England can also learn from other countries, including Scotland and Wales, which have taken a bolder approach to improving population health. Effective local system leadership is also vital. The complexity of local structures means that approaches will vary from place to place with health and wellbeing boards, integrated care systems (ICSs), sustainability and transformation partnerships (STPs) and political leaders such as elected mayors all having key roles to play.

Our recommendations to strengthen leadership for population health include the following.

- Population health and health inequalities must be at the heart of the role of the Secretary of State for Health and Social Care.
- The government should announce a new cross-government strategy to reduce health inequalities.
- The government should ensure that arrangements are in place to co-ordinate action on population health across Whitehall departments and that all relevant government policies are subject to a health impact assessment.
- Lessons should be learnt from previous successes in tackling health inequalities and from the experience of other countries, including Scotland and Wales.
- Local system leaders and politicians should champion population health. Local authorities have a key role to play working with the NHS and other partners including through health and wellbeing boards, STPs and ICSs.

Roles and accountability

At national level, greater clarity is needed about the roles and responsibilities of NHS England and Public Health England in particular. Accountability for improving population health at local and regional levels is currently weak and confusing. Strategic bodies, such as HWBs, STPs, ICSs and political leaders such as elected mayors have important roles to play in ensuring that local actions are aligned with national goals. The NHS long-term plan, new five-year STPs to be developed in 2019 and the forthcoming Green Paper on prevention provide opportunities to clarify this.

Appendix 2 What Rethink Mental Illness thinks about the NHS 10 year plan. Blog by Lucy dated 7.1.19

You might have seen the coverage today about £billions more for the NHS with a big focus on improving mental health services. But with people who are most ill waiting the longest for mental health treatments, will this new money stretch far enough to help those most in need?

Mental health services have been a binary picture – on the one hand we've seen huge improvements to support for people with mild and moderate mental health problems in need of Cognitive Behavioural Therapy (CBT) through the rollout of Improving Access to Psychological Therapies (IAPT). There has also been much needed investment into early interventions for new mothers and people with their first experience of psychosis.

Yet a recent Rethink Mental Illness report, Right Treatment, Right Time, found that people severely affected by mental illness, for example with schizophrenia or personality disorder, have been facing a bleak picture. They have been unable to access the services they need in the time they need them with people on average waiting 14 weeks for an assessment and a further 19 weeks for treatment.

We have therefore been on tenterhooks for months now waiting to hear about what the NHS decision makers were planning to do about this significant inequality.

In November 2018 we voiced our concerns through a piece published in The Sunday Telegraph. The piece outlined our call for there to be a focus on core community services for people severely affected by mental illness in the NHS Long-term plan, supported by increased funding, workforce and data.

We're delighted that we've been listened to and there's a lot to be pleased about.

Overall there's a strong reaffirmation to achieving parity of esteem between mental and physical health and a clear focus, for the first time, on severe mental illness. In particular:

- Aims to give 370,000 people severely affected by mental illness more choice and control over their care by transforming community services and increase their access to mental health therapies and trauma-informed care, and physical health and practical support. Directly linked to Rethink Mental Illness' calls, we're pleased to see a commitment to trial a four-week waiting time standard to community mental health teams.
- 24-hour mental health crisis support in the community and improved access to 'safe havens' in the community, like the crisis houses and cafes Rethink Mental Illness provide. There will be specific waiting time targets introduced from 2020.
- Continued commitments to end out of area placements for people needing hospital care by 2021 as well as funding to upgrade hospitals themselves following calls in the recent Independent Review of the Mental Health Act.
- Increased overall funding for children's mental health to deliver expansions to CAMHS services from ages 0-25 and ensuring there's mental health support in every school.
- Improved specialist perinatal mental health care from preconception to 24 months after birth for mothers and fathers.

These ambitions are bold and promising, particularly within the constraints of how much extra funding NHS England were provided by the Government and considering the acute workforce shortage.

Overall there will be proportionately more funding for mental health than other areas with £2.3bn a year more until 2023/24. However, following research we carried out with the Institute for Public Policy Research (IPPR), we know this still won't be enough to achieve true parity of esteem.

We also know the 5-10 year timeframe for most of the ambitions can be seen as frustratingly long and a huge part of this is because there simply isn't enough NHS staff available. However, we are encouraged by the focus on improving supply and the skill mix of the mental health workforce. It is crucial this is made a priority as only then will we see delivery on the other commitments within the timeframes set out in the NHS Long Term Plan.

Overall, this plan goes a long way to address the needs of people with complex mental health problems like schizophrenia and bipolar disorder. That's a first and something we have long campaigned for. Like all plans, it's about what action comes next that really matters.

Rethink Mental Illness will now be working closely with NHS England, the Government and local commissioners to ensure the new focus on community services is rooted in the needs of people severely affected by mental illness and provides mental health care fit for the 21st Century. We'll keep you posted…