Parity of Esteem and Systems Thinking. A Theory Informed Qualitative Synthesis

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Abstract

Background: UK policy recognises the interdependence of physical and mental health, but the failure to define Parity of Esteem (PoE) in any depth, challenges its implementation. There are at least two shortcomings in current PoE implementation; the lack of specificity in its operational components and progress indicators and the sub-optimal 'siloed' approach to its redress.

Methods: This is a descriptive qualitative study employing 27 qualitative interviews and the World Health Organisation (WHO) system domains as a framework for the thematic analysis.

Results: Examining the current strengths and challenges of systems in mental and physical healthcare using the WHO domains and macro, meso and micro levels, identifies specific actions to redress inequity between mental and physical health provision.

Conclusion: The evidence suggests that moving PoE from rhetoric towards reality requires new configurations with a systems orientation, which uses macro, meso and micro levels to analyse and understand the complexity of relations within and between domain levels and reorienting funding, training and measurement. This requires embedding new competencies, infrastructures and practices within an effective learning healthcare system.

Introduction

There are large inequalities between the physical health of people with and without mental health conditions. Inequalities manifest as a significantly higher risk of dying earlier from preventable physical illnesses among those diagnosed with mental health difficulties and pervasive barriers to accessing healthcare^{1,2,3,4,5,6,7}. Achieving parity between physical and mental health is a national priority, but there are many challenges to overcome and the area is fraught with bureaucratic, regulatory and structural complexity^{8,9}.

The concept of parity of esteem (PoE) in healthcare began with its enshrinement in USA law under the Mental Health and Parity Act (MHPA, 1996), with further application of the concept occurring through the Mental Health Parity and Addiction Equity Act (MHPAEA, 2008)¹⁰. The UK coalition government introduced PoE in 2011, in the White Paper 'No Health without Mental Health', promoting equality between physical and mental health care¹¹(p. 64, Para. 7.1). This paper recognised the interdependence of physical and mental health, but failed to define PoE in any depth, challenging its implementation. In 2012, the Health and Social Care Act made parity a requirement in law, resulting in an NHS Mandate in 2015/16¹² (p.16) and ensuing policy documents and professional guidance^{13,14,15}. There remains however, opacity regarding its definition and its use in health and social care settings.

One way of reframing the numerous conversations and complexity surrounding parity of esteem is to employ systems thinking. The utility of a systems-level approach may overcome at least two

shortcomings in current PoE implementation: i) the lack of specificity in its operational components and progress indicators and ii), the sub-optimal 'siloed' approach to its redress.

The World Health Organisation [WHO] framework outlines the core building blocks necessary for developing and sustaining effective health systems ¹⁶. The six critical domains are; financing; service delivery; the health workforce; information; medicines and technology; and leadership and governance. In theory, improvements to the quality, responsiveness and coverage of all these elements should lead to improved health equity and parity. This approach enables a shift in thinking from a more linear and segmented view towards more complex systems founded on synergistic components ^{17, 18, 19}.

This paper frames PoE within this systems-based approach to examine the current strengths and challenges of this concept in mental healthcare and identify specific actions to redress inequity between mental and physical health provision.

Methods

This study conforms to COREQ guidelines, using a descriptive qualitative design, informed by the WHO health systems framework ¹⁶.

Sample and recruitment

Study participants were local, regional or national key informants in mental health policy and practice (n=27). Purposive and snowballing sampling identified local and national key informants. The basis of selection rested on the premise that participants possessed a critical understanding of parity of esteem within and across sectors.

Recruitment occurred between June 2020 and December 2020, initially through an advert on the local healthcare intranet site and via community groups within Greater Manchester. Recruitment snowballed through social media and participants' own contacts to form a national lens, ending when reaching data saturation.

Twenty-seven participants self-selected by agreeing to an interview and providing their contact details. Participants included mental health care providers, physical health care providers, policy-makers, service commissioners, mental health charity workers and political party members (see Table 1).

Table 1
Characteristics of participants

Role	N /27
Mental healthcare providers	10
Physical healthcare providers	9
Service Commissioners	1
Mental Health Charities	1
Politicians	2
Public Health Professionals	2
Medical education providers	2

Interviewing

The research team, developed, piloted and reviewed a semi-structured interview schedule. The current COVID pandemic prevented face-to-face interviews and necessitated online (Zoom) interviews with digital recordings. Two female researchers (VB and AB), with experience of interviewing from a public health background and with an interest in mental health, interviewed participants between September 2020 and February 2021. Interviews lasted between 40 -70 minutes. Verbatim transcription occurred through an independent, ethics-approved transcriber prior to analysis.

Ethical approval

and consent to participate

The University of Manchester granted proportional ethics [Ref. no. 2020-8567-15631] and the study conformed to the ethical norms and standards in the Declaration of Helsinki. Participants were given the information sheet and contacted after two weeks, leaving them time to consider the study and ask questions. The consent procedure discussed the study, asking participants if they had any further questions before obtaining informed consent to participate. Participants consented to the use and analysis of data for publication and teaching purposes. Anonymising participant transcripts (PT) assured anonymity. All data was password protected and kept on encrypted servers. Deletion of interview recordings occurred immediately post-transcription. The datasets generated and/or analysed during the current study are not publicly available because they contain identifiable data.

Results

Analysis used the domains from the WHO systems framework ¹⁶ as a lens through which to view data and develop themes. It also applied macro, meso and micro levels to identify barriers and facilitators. Table 2 illustrates the various themes mapping onto system domains and levels.

Table 2

Sub-themes mapping onto domains illustrating barriers and enablers at macro, meso and micro levels

WHO Systems Domain	Mapping of sub-themes	Explanation of themes and sub-themes	Macro, meso and micro Barriers	Macro, meso and micro Enablers
Leadership and Governance	<ul style="list-style-type: none"> • Policy and action plans on parity • Shared decision-making 	Working from National level policy to service level delivery to ensure inclusive care, addressing individual need and including families where possible, whilst incorporating parity.	Macro level	Macro level
			Policy on PoE. Equality Legislation and Standards.	Equivalent policy priority.
			Meso Level	Meso Level
			Micro Level	Micro Level
			Lacking insight into patient and carer's experiences of Mental Health.	Sharing decisions with patients and carers or families where possible.
Financing	<ul style="list-style-type: none"> • Funding for services • Targets and incentives. • Mental health estate 	The impact of inequitable funding for mental health care and inadequate provision, which create an impact on both service providers and users. Targets and incentives should develop holistic care, but limited by their definitions.	Macro Level Inequitable funding for mental health. Little consideration concerning the complexity of mental health conditions.	Macro Level Campaigning for funding.

WHO Systems Domain	Mapping of sub-themes	Explanation of themes and sub-themes	Macro, meso and micro Barriers	Macro, meso and micro Enablers
			Meso Level Inadequate resource allocation. Different funding models. Lack of investment in the mental health estate. Unclear targets. Targets fail to consider people with complex mental and physical health problems.	Meso Level
			Micro Level	Micro Level
Service Delivery	<ul style="list-style-type: none"> • Access to quality care • Integrated care and collaboration • Informal caregiver involvement • Person-centred care 	Accessibility and availability of services including issues such as acceptable waiting times, medication reviews, follow-ups and availability of a range of services. Integrated multidisciplinary teams learning from one another and working together with families of individuals to provide continuity of and person-centred pro-active care that takes into account differences in social environment and levels of available support.	Macro Level	Macro Level Equivalent clinical priority

WHO Systems Domain	Mapping of sub-themes	Explanation of themes and sub-themes	Macro, meso and micro Barriers	Macro, meso and micro Enablers
			Meso Level Inaccessible and 'patchy' services. Poor consistency of service provision. Variable availability between areas and regions. Inadequate crisis care. Lack of placed based care. Long waiting lists for children's mental health. Poor integration of teams.	Meso Level Suggested multiple access points to gain entry to services. Integrating care into the community.
			Micro Level Lack of time.	Micro Level Involving families, formal carers and individuals in the decision-making environment. Person-centred care.
Workforce	<ul style="list-style-type: none"> • Education, training and continuous professional development (CPD) • Staffing numbers 	Education and training for all healthcare workers to include mental health, alongside CPD for understanding the aims of the Mental Capacity Act and reinforcing insight into difference. Ensuring adequate staffing of services to ensure equitable delivery of care.	Macro Level Agreement of educational curricula without consideration of meso and micro levels.	Macro Level

WHO Systems Domain	Mapping of sub-themes	Explanation of themes and sub-themes	Macro, meso and micro Barriers	Macro, meso and micro Enablers
			Meso Level Poor staffing levels. Workloads. Lack of focused education, training and CPD for staff enabling consideration of the holistic body. Lack of integrated mental health awareness.	Meso Level Having an understanding of the impact of the social determinants of health on patients and carers.
			Micro Level Discriminatory staff attitudes. Lack of cultural competence. Inability to engage with diversity.	Micro Level

WHO Systems Domain	Mapping of sub-themes	Explanation of themes and sub-themes	Macro, meso and micro Barriers	Macro, meso and micro Enablers
Information and Research	<ul style="list-style-type: none"> • Access to reliable data • Measurement and benchmarking • Parity in research 	Access to reliable data in order to improve systems. Measurement and benchmarking for conditions to provide indicators that are more reliable. Parity in research funding to explore and improve outcomes.	<p>Macro Level</p> <p>Lack of parity between physical and mental health research.</p> <p>Lack of reliable data.</p> <p>Lack of clear indicators.</p> <p>Measurement uncertainty for indicators.</p> <p>Ambiguous benchmarking.</p> <p>Introducing and then removing QOFs.</p>	<p>Macro level</p> <p>Equivalent research priorities for physical and mental health.</p> <p>Providing Quality Outcome Frameworks (QOFs).</p>
Technologies and Medical Products	<ul style="list-style-type: none"> • Choice of treatments • Shared information systems 	Access to and choice of ensures equitable access to the latest evidence based treatment and products. There are also shared information systems to ensure joined-up care. Electronic records are linked and available nationally at varying levels to different professionals and primary care systems	<p>Macro Level</p> <hr/> <p>Meso Level</p> <p>Lack of accessibility for electronic records at all levels.</p> <hr/> <p>Micro Level</p> <p>Patients prevented from making choices because of perceptions about their mental health status.</p>	<p>Macro Level</p> <hr/> <p>Meso Level</p> <hr/> <p>Micro Level</p> <p>Patients and carers enabled to make decisions and choices about treatment.</p>

Domains: Barriers and enablers of PoE at macro, meso and micro levels

Leadership and Governance

Key themes for this domain included a) policy and action plans on parity and b) shared decision-making. Policy and action plans at the macro level for parity of esteem appear to have created barriers due to a lack of clarity and definition in the ways that parity may be achieved^{20, 21}. Broad enablers for PoE at the macro level included “campaigning for mental health funding” (PT.19, p.3), and “making sure mental health problems have equivalent policy priority”(PT. 18, p.2), but the method of enactment of these initiatives required meso and micro level thinking. Specifically, Participants argued that setting equality standards at the macro level such as everyone having a maximum of a two-week wait prevented shared decision-making, creating barriers because it worked against people experiencing a mental health crisis, tending to treat all mental health conditions as the same with little consideration for diversity, or complexity. “Why is it that people with psychosis, or a psychotic crisis, should expect the equivalent, or parity, if you like, of access, as someone with [...] cancer?”(PT.1, p.12).

Shared decision-making inevitably links to patient-centred care, and equity in this context meant having the autonomy to build a relationship and respond to a patient as a person situated in a particular psychosocial and economic environment. The majority of this activity occurred at the meso and micro level. “To understand that what generates good diabetic care, is often understanding psychological and social contexts in which people have their difficulties” (PT.1, p. 9).

Financing

Key themes for this domain included a) funding for services, b) targets and incentives and c) the mental health estate.

All participants mentioned the central role of funding; suggesting that a system was constrained by inequitable funding was both a challenge to and a manifestation of a lack of PoE. Participants perceived that moving funding around to prioritise one area over another perpetuated mental and physical health inequalities, inadvertently setting the two fields up as financial competitors rather than an integrated healthcare goal. “In a resource constrained system, if we want to give more to someone else we have to take it from one area and move it to another”(PT. 27, p. 14).

Integrated care systems occur at meso levels but remain heavily dependent on funding from the macro level, with mental health appearing secondary to physical health “there's always going to be people with what appear to be hugely significant health problems physically that “trump” mental health problems” (PT. 27, p.5). Participants mentioned further local tensions in resource allocation and funding for acute and mental health services, emanating from this inequity. “[...] each ICS (integrated care system) has a sort of capital spending limit, which has to be shared between its acute hospitals and its mental health trusts. Mental health is always a relatively small player” (PT. 6, p.4). Participants believed that this Cartesian vision of mental and physical health limited the ability to gain larger amounts of funding from the macro level.

Participants also discussed the inadequacy of mental health funding for children and adolescents, suggesting local and whole system inequalities maybe further exacerbated in some populations. “What

we focus on (young people and mental health) – is so sort of underfunded and under-prioritised compared to the rest of the healthcare system” (PT.12, p.3).

Participants perceived a need for adequate resourcing at meso levels to meet policy and service targets “the need is to focus resources and provision to meet those targets. I think the challenge with it is that you have to have adequate resources to do that” (PT. 21, p. 10).

For some participants targets added a new level of complexity that risked whole system improvement. “The danger with that is we get narrowly focused on how many people are accessing psychological therapies, and a more encompassing measure looks at people who maybe don’t want to access psychological therapies, but do still want support” (PT.2, p. 12). For many participants in the current study, targets did not appear to address provision for people with complex mental and physical health problems, resulting in a lack of parity. “There are waiting time targets for psychological therapies, but it seems that not really that much is done around those people who fall through the gaps and who are too complex” (PT.2, p. 7). The complexity of conditions appeared to be an area receiving very little consideration at macro level when allocating funding. “The other big test of the complexity of parity of esteem, in a sense, is that people don’t have one problem. So people don’t just have a psychological difficulty, or they don’t just have diabetes, they often have multiple problems” (PT. 1, p. 14). At worst, participants suggested that targets might lead to a reduction of total effort at the meso level “sometimes what happens then is people only focus on the targets, rather than the bigger picture” (PT. 5, p.8).

A considerable challenge involves clearly identifying indicators for benchmarking PoE progress “the indicators are going to act as this kind of galvanising force around an area that the targets are going to do that so you have to be very specific about what it is you want change” (PT. 8, pp.6-7).

Participants perceived that a lack of funding at the macro level affected both the physical environment of mental health services at meso level and the availability and quality of care for people with mental health problems at micro level. A lack of investment in physical infrastructure affected mental health care creating “facilities that are not fit for purpose, with people still in dormitories and wards that are not acceptable in this day and age” (PT. 6, p. 7). A concomitant impact on patient wellbeing and long-term recovery was evident. “Often in emergency departments there will be a particular area or a particular room where someone who is experiencing a mental health crisis, or presenting with a primary mental health need, will be placed. Often those places aren’t very well looked after; they’re not very welcoming, they’re not very therapeutic.” (PT. 25, p. 5).

Service Delivery

Key themes in the service delivery domain were a) Access to quality care, b) Integrated care and collaboration, c) Informal caregiver involvement and d) Person-centred care.

Macro level enablers for participants included “making sure mental health problems have equivalent clinical priority” (PT. 18, p.2).

Crisis services in particular exhibited many barriers to support and care at a meso level. “How easy it is for people with mental health problems and their families to get support when somebody’s in crisis. How responsive is that service? The answer is it isn’t” (PT 11, p.5).

Participants discussed the accessibility of formal services and the sub-optimal role that GPs may play as gatekeepers to this system “It’s no criticism of GPs, but Access Points rely heavily on people going through GPs to access the system.” (PT 3, p.5). Participants offered potential solutions such as meso level enablers involving multiple access points and better health care integration and support within communities, potentially reducing inequalities in referrals for people with mental health problems and relieving the burden on GPs by employing more community-based health care for mild to moderate conditions. “There needs to be equity of access once you pass the threshold and therein lies the problem, because access for someone with a mental health problem, even to a service which has parity of resource, has to be different to someone with a physical health problem.”(PT 27, p. 6). “[...] the positive change that needs to take place, that would improve mental health would be, better integration with the community. That actually that applies to all long-term conditions.”(PT 8, pp. 5-6).

Participant’s perceptions also focused on the importance of availability of services at meso level “The early intervention psychosis programmes are really good examples. There aren’t enough of them and people can’t get at them and, you know, so they’re patchy, it’s not uniform.”(PT. 25, p.5). Barriers to early intervention services and crisis care came up numerous times in people’s narratives across adult, child and adolescent services. Given the possible impact of early mental health difficulties across the lifecourse, participants viewed deficits in children’s care as particularly salient. “If you have a child who is anxious and depressed, to the point it’s getting in the way of their development, and they are ten years old, being on a waiting list for a year, is a tenth of their lifespan that they’ve not been functioning for and they pay a very heavy developmental price.”(PT.5, p.10).

A lack of continual and follow-up support for people and their supporters when experiencing mental health crisis reinforced a lack of parity for acute and mental health service user, with caregivers seen as instrumental in negotiating access and responsiveness from mental health services. Perceived enablers at the meso level involved carers and families; “Family members are a really important part of navigating the health systems, advocating for the health systems, reminding the health systems, they alert if there’s a problem going on. [...]”(PT 1, p.18).

Participants discussed involving families and formal carers as facilitators for developing greater levels of acceptability. “You’ve got to start with the service users, their families and the professionals that are directly involved in the coordination and delivery of their care and support.”(PT 13, p. 14). Without the support of families and formal caregivers, professionals may struggle to deliver acceptable, effective and equitable care, but this itself raises challenges at the micro level in terms of language used, clinical culture and power differentials.

Barriers to patient-centred care involved time and pressure on services “time is an important factor because of increasing service demands and pressure on clinical services. Sadly, even with the best will,

we don't have the time to sometimes delve into a little more detail." (PT. 24, p.5). Without the time to explore with patients and their carers important details and inclusion in the patient professional encounter then 'no decision about me without me' ²² (p.3) is unlikely to occur. Some participants discussed person-centred care as both a facilitator and barrier to parity. "Making sure that the patient is able to tell you more about their needs than anything else"(PT16, p.6). However, "With mental health I think everyone is a bit more fearful; they remove themselves, they maybe don't want to enter in a discussion" (PT. 23, p.6). It would appear that for parity to occur in choice and decision-making there needs to be more training in facilitating individuals, families and carers to become part of the decision-making environment.

Workforce

Key themes for this domain were a) Education, training and continuous professional development (CPD), and b) Staffing numbers.

Participants perceived the impact of lack of funding on staffing numbers at macro level as a challenge to service delivery at the meso level "When patients come into ED, they're often waiting for the mental health liaison team. They're quite often short-staffed, underfunded" (PT. 23, p. 3). They felt that a lack of resources had a direct impact on staff themselves, particularly in early intervention and crisis care services, which then exerted an effect at the micro level: "the staff are under so much pressure, they have no resources and not enough staff" (PT. 22, p. 11).

"When someone's in a mental health crisis, they should not be left to not know where to go. Or to not have support because there aren't enough resources or the service isn't open" (PT. 2, p. 7).

Staffing was an issue throughout participant interviews, particularly at the meso level for

The workforce is a substantial resource within the services, and arguably, it is important to keep abreast of new evidence and ensure holistic care is prominent. Some participants highlighted a siloing of education and training which focused mostly on physical health "If I'm trained as a physician I'm trained in physical health. I learn to be blind to mental health problems"(PT. 27, p.4). Cartesian duality appeared reified by education "you know we're definitely trained in splitting people's bodies and minds."(PT1. P, 9). This disjointed training at the meso level disabled healthcare practitioners, affecting service delivery at the micro level, because there are barriers to effective communication and asking people about their mental health. "Mental health nurses, don't feel as confident with physical healthcare as we could, because we haven't been trained to the level that we need. The reverse is true for acute care nurses, they don't get any mental health training and they're scared" (PT. 10, p. 4).

Information and Research

Key themes for this domain were; a) Access to reliable data; b) Measurement and benchmarking; and c) Parity in research.

Acknowledgement came from participants regarding the lack of parity between physical and mental health research “you’d want to see some parity in mental health research. Of course, it’s way behind other health areas.” (PT. 14, pp. 7-8). Reducing barriers at the macro level would facilitate more equitable meso level advances. Whilst broad macro level enablers for participants included “making sure mental health problems have equivalent research and funding priority”(PT. 18, p.2), more specificity was evident in some participants responses.

Participants discussed meso level barriers to accessing reliable data because of variations in coding and collecting data. “Quality of the data is still really poor and the way that different NHS trusts collect the data, there’s just a huge amount of variation. How can you assess the effectiveness of the system, the quality of care, if first of all you’re not collecting the right data?”(PT. 12, p. 14). Enablers involved standardising data aiming towards quality improvement and “really understanding the data and what you’re measuring, really understanding the change cycle that you’re implementing, and then sustainability about the metrics that you’re collecting, to measure it.” (PT. 21, p.15). Another participant suggested that there was a pressing need “to invest more time and energy and effort and research into what patient reported outcomes (PROMs) would be of value to people.” (PT. 24, p. 6).

Being able to judge the efficacy of a system and need for resources becomes challenging if the data is unreliable. It also makes requests for further resources difficult.

Within healthcare, benchmarking links to targets, incentives and metrics and usually classified into one of four categories: productivity, quality, time and cost-related. This allegedly establishes standards of excellence and improves services and quality²³. Participants perceived that benchmarking was important “how are we doing on this indicator, compared to the national average? I would do it more by benchmarking the key indicators.”(PT. 14, p. 8). This also underlined considerable operational complexity: “How you measure what the outcomes are for something like mortality? Do you then break it down for different mental health conditions?” (PT. 3, p.11).

At the meso level, participants gave positive examples of enablers such as Quality Outcomes Frameworks (QOFs) involving integrated care addressing physical and mental health. “They access a dietician, get to the optician, see the podiatrist, and go for their regular physical health checks. They should have an ECG and bloods taken at regular intervals at least once a year. People with bipolar disorder and schizophrenia should have that in general practice. There was a QoF around that, but that’s been removed” (PT.17, p.7). While participants perceived incentivising physical and mental health through the introduction of yearly health checks at the meso level as an enabler, the potential for the mis-coordination or instability of these approaches was a prominent barrier.

Technologies and Medical Products

Key themes for this domain were a) Shared information systems and b) Treatment choice.

This domain was least mentioned. Participants who did discuss PoE under this domain typically perceived barriers to care emanating from a lack of shared information systems at the meso level. This occurred primarily when they were attempting to support inpatients with mental health care. Inflexible interpretations of confidentiality and data protection appeared to present specific barriers. For example, blocking access of healthcare staff to scans and appointments sent to the patient's home address, even though they were in-patients in a mental health unit in the same hospital grounds:

"They have a system within the main hospital where all the CT scans are reported and actually held electronically, but we don't have access. We have tried to get access and we have failed. The radiologists are telling us, 'we cannot give you access to the system, we cannot email you the result, and you have to physically come'. So, we have to leave our building, walk across the hospital site, go to another building and get the scan result. When my junior doctor arrived there they said, 'oh no, we are not giving it to you'. So, they can't email it to us, they can't physically give it to us, they can't put it on the system, so I'm not really sure how we're supposed to access it." (PT17, p.4).

Other participants discussed barriers to treatment choices resulting from perceptions around mental health at the micro level "I would always discuss treatments and the choice and the availability of different treatments to a patient and, you know, involve, them [...]. In mental health, for some reason, a different idea is that they can't make that decision or they shouldn't have that decision" (PT.23, p.9). This participant appeared to suggest that professional or institutional discrimination might result in patients with mental health problems ultimately having less choice and by implication iniquitous or sub-optimal care standards. "They've not had the same choice in treatment, or [...] I'm not going to Steri-Strip...I'm not going to suture them because, you know, they've self-harmed, they'll probably rip it out and self-harm again, so it's not really worth it." (PT. 22, p.3-4).

Discussion

The aim of this paper was to frame PoE within a systems approach in order to deconstruct it into clearly defined domains and system levels and describe facilitators and challenges. Delineations between macro, meso and micro levels are not always clear, for example, in the domain of service delivery, training deficiencies are meso level but could also be micro level because this affects patients. Another argument is that it could be macro level because policy decisions can alter healthcare curricula or CPD requirements. Table 2 displaying the domains and levels may not be comprehensive, but for this study, there appear to be more barriers at macro and meso and micro levels across domains than enablers for PoE.

The domain for Leadership and governance exhibited enablers at macro and micro level through policy and guidance, but simultaneously participants viewed these actions as barriers because of a lack of clarity. There was no evidence of leadership and governance at meso level, leaving decisions about PoE to individuals. Setting standards at the macro level such as a two-week wait for all conditions created inequity because of the failure to acknowledge difference and complexity between and within conditions

and people. Shared decision-making at the micro level acted as an enabler for parity, but a barrier at the micro level, because of a lack of time, creating a negative impact in service delivery.

Importantly, financing exerted an impact across all domains. Participants suggest that a lack of funding and resources creates inconsistencies in resource allocation, care quality and outcome measurement. The failure to consider complexity remains unaddressed, affecting multiple health system domains and implementation levels. Governments rightly aim to achieve real value-for-money through public investment in service delivery. However, the lack of recognition concerning the complexity of the environment and the impacts of policy changes on service delivery appears to exclude equitable care improvements and measurement. For mental health, outcome measures need to be valid, reliable, sensitive to change, comparable across a range of service users and meaningful for both clinicians, patients and their supporters^{24,25}. The main problem that the participants in this study identify is that implementing outcomes reactively maintains contractual and funding requirements rather than enacting well-defined and appropriate goals, which may more readily lead to equity.

At micro-level, enablers may include the introduction of more meaningful outcome measures reflecting improvement in social and occupational functioning, mental health symptoms and distress, and physical health and wellbeing. This intention would strengthen progress in the information and research system domains because whilst outcomes measurement offers valuable information on the impact and effectiveness of a service, it also presents its own challenges. For example, valid outcome measurement may be dependent on the availability of reliable evidence and data capture tools and affected by the complexity of systems at meso level.

The Service delivery domain focused heavily on 'Access to care', which demonstrates intrinsic and direct links to outcomes measurement and well-defined goals instigated at the macro and meso levels²⁶. Access to quality care is currently difficult to measure with certainty because it is a theoretical concept encompassing different aspects and dependent on the exact definition and the context of measurement²⁷. Enablers at the meso level may include multiple access points to support services in the community, extending the reach of community support services and facilitating access to crisis care before symptoms or behaviour becomes unmanageable. These initiatives may present as quantifiable improvements at the micro level through continual review, follow-up with patients and family and caregiver support to prevent escalation of symptoms. Research suggests that including family members in decision-making and choices is a positive approach to mental health, as long as agreed by all^{22, 28, 29}.

Within the Workforce domain, the siloing of education and the creation a Cartesian divide appears in urgent need of address, leading from a macro-level reorientation of training, education and CPD focused on the holistic body. This has potential to initiate gains in multiple system domains, including the Technology and Medical Products domain at the micro level where stereotypical perceptions about mental health may still be limiting treatment choices. It also affects patient-centred care at the micro level in the Service delivery domain. The financing domain, in itself will directly affect the workforce domain,

dictating staffing levels at the meso level and resources, and the development or otherwise of a supportive workforce culture.

The concept of a learning health system (LHS), in which an organisation builds knowledge or evidence, embeds quality improvement practices as standard practice, actively engages patients and family members and supports further learning³⁰, offers a potentially fruitful approach to building parity across multiple interacting domains and levels of healthcare. Taking these four elements of the learning healthcare system and using them in a PoE focused systems-based approach may offer important traction.

Study limitations

The sample limited collection of data during lockdown in 2020/2021. Our assessment of macro, meso, micro levels within the study represents a professional perspective, and future studies may garner a more comprehensive insight from everyone involved across different settings and levels.

Conclusion

Moving PoE from rhetoric to reality suggests the need for new configurations that have a systems orientation. This includes new approaches from macro to micro levels, which focus on reorienting funding, training and measurement and that are oriented towards understanding the complexity of relationships within and between domains and levels. This requires ongoing development, monitoring, evaluation and may most usefully occur by adopting a whole systems approach and by embedding this principle within an effective learning healthcare system.

Declarations

Ethical approval and consent to participate

The University of Manchester granted proportional ethics [Ref. no. 2020-8567-15631]. The study conformed to the ethical norms and standards in the Declaration of Helsinki. Informed consent was all participants consented to participate. Page 6 contains further details of the process employed.

Consent for publication

Not applicable.

Availability of data and materials

The qualitative data generated and analysed during the current study are not publicly available because they contain personal data, for example, job roles, place of work, colleague names, family names and circumstances, which could identify the participant. Redacted data are available from the corresponding author on reasonable request.

Competing interests

The authors declare they have no competing interests.

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None

Author's contributions

P B and K L conceived and designed the study, assisted with data analysis and interpretation, preparation and commenting on the paper. AB collected the data and assisted with commenting on drafts. JO analysed and interpreted the data, prepared the main draft and revised the paper after comments from all authors. All authors agreed on the final draft.

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