NHS PRIORITIES AND REFORM IN DEVELOPING A LONG-TERM PLAN AND MULTI-YEAR FUNDING SETTLEMENT FOR ENGLAND

THE ROYAL COLLEGE OF PSYCHIATRISTS' PROPOSALS FOR CHANGE

About the Royal College of Psychiatrists

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and for setting and raising standards of psychiatry in the UK. The College aims to improve the outcomes of people with mental illness and the mental health of individuals, their families and communities.

To achieve this, the College: sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; and works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

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1. Executive Summary

The NHS turning 70 is a remarkable achievement. Since the publication of the *Five Year Forward View* (FYFV) in 2014, the NHS has embarked on an impressive programme of work to take the strain off A&E, foster the resilience of general practice, help frail and older people stay healthy and independent, improve cancer survival rates, and increase access to evidence-based services for people experiencing a mental illness.[1]

Mental health services have undergone a phenomenal transformation. In recent years, there has been an unprecedented focus on mental health within the NHS, primarily through the publication and roll-out of the *Five Year Forward View for Mental Health*[2] (FYFVMH), as well as a step-change in the priority given to mental health by politicians, health leaders and opinion formers.

The additional investment is making a significant difference to people's lives, and there is the opportunity to make more progress to address unmet need, supported by further funding and a new strategy. The Prime Minister's pledge to bring forward a long-term funding plan for the NHS is welcome and comes at a time when mental health is high on the nation's agenda for future NHS funding.[3]

As we commemorate the 70th anniversary of the NHS, it is important to recognise and celebrate these achievements in mental health, while looking to shape its future. The Government should set an aspiration for what patients, professionals and the public can expect from their mental health services over the next 10 years, recognising the need for a culture shift to create working environments where staff can deliver safe, effective and efficient care to patients to the best of their ability, with a greater focus on person-centred care, and less on red-tape and needless bureaucracy.

This paper sets out the College's proposals for change. It includes an ambitious roadmap to achieve the biggest expansion in access to mental health services across Europe through integrated models of care, with equal attention given to people with severe and enduring mental illnesses as those with common mental health problems. It also includes supporting policy recommendations, workforce solutions and the necessary funding commitments. In doing so, we consider both what the NHS might look like in 10 years' time and the progress made in the FYFVMH. Throughout, we seek to build on the ambitions of this strategy and urge that focus is not lost on delivering the final three years of this important plan.

The NHS at 80: developing the Ten Year Forward View (10YFV)

Principles
The development of the NHS Long-Term Plan should be underpinned by the following principles:

- **Ambition**: commitment to achieve parity of esteem between mental and physical health.
- **Realism**: recognising the need for pragmatism, national and local leaders must think carefully about the phasing of improvement over the next 5 to 10 years to ensure the system can cope with demands.
- **Inclusiveness**: meaningful consultation and engagement with the public, patients, carers and staff, drawing on a similar approach adopted by the Mental Health Taskforce in 2015.
- **Transparency**: an open and transparent process for developing the plan and allocating new monies, and a similarly transparent governance process for its implementation.

Process
Developing the Long-Term Plan between July and mid−late autumn is a significant challenge. There needs to be a major focus on engaging with the public about the future of health and care services over the next 5 to 10 years. The public's demand for better mental health services is clear: research from Ipsos Mori puts mental health as the public's second major priority[4] but the narrative around people living with severe and enduring mental illnesses needs to develop further. People living with these illnesses should receive the same benefits from service improvements as people with common mental health problems have received

over the past 10 years. The 'NHS Assembly' should consist of leaders with expertise in mental health from national, clinical, patient and staff organisations, the voluntary, community and social enterprise sector.

Priorities

The NHS needs a mental health service that is flexible and responsive to the needs of a changing population. The plan should recognise that improvements in mental health care can alleviate some of the pressures in other parts of the healthcare system, including the national priorities to reduce delayed transfers of care, improve the productivity of staff working across different settings, and achieve a more efficient healthcare system collectively across a local health economy. It should be co-produced by other government departments to align initiatives that promote and support good health, such as housing, schools, communities, criminal justice, welfare, social care and public health.

All our proposals are designed to empower the disempowered, with a much greater focus on improving care for excluded groups, taking us closer to achieving our vision of parity of esteem.

We call on the Department of Health and Social Care (DHSC), other relevant government departments, NHS England (NHSE), the other ALBs of the NHS, and relevant organisations to:

1. Commit to the biggest expansion in access to mental health services across Europe, empowering the disempowered with a much-needed focus on tackling inequalities, fit for a modern NHS.
2. Enable the NHS to become the safest, most effective, and transparent health system in the world with mental health trusts leading the way.
3. Empower mental health leaders to develop the healthcare services of the future through Integrated Care Systems (ICS) and Providers (ICP).
4. Build a strong and resilient mental health workforce with 70,348 more staff on the ground by 2028/29 (excluding Mental Health Support Teams), of which 4,218 will be psychiatrists.
5. Invest an additional **£6.198bn** (£5.677bn revenue and £521m capital) in mental health services between 2019/20 – 2023/24 and a further **£7.456bn** (£6.520bn revenue and £936m capital) between 2024/25 – 2028/29. This will take spending by CCGs and NHSE on mental health from **10.8%** in 2017/18 to around **13.1%** in 2028/29 of the total estimated NHS England budget. This would mean that the funding uplifts required for delivery would be in the range of **5.5% to 6.8%** above inflation for the period up to and including 2023/24. Spending growth could then slow slightly to between **4.3% and 4.6%** above inflation for the remainder of the period to 2028/29, with the majority of workforce commitments by then in place.

Our proposals are ambitious yet deliverable (Figure 1). If achieved, they will result in tangible benefits across the country, placing the NHS in England as the world-leading healthcare system for mental health, with demonstrable improvements in access, quality of care, outcomes and efficiency by 2028/29.

Chapter 2 considers what the NHS might look like in 10 years' time, based on population growth and the associated incidence and prevalence of mental illness in the population. Chapter 3 considers the progress made since the publication of the FYFV in terms of policy implementation, service improvement, the position of mental health trusts, and systems. Chapters 4 to 16 describe the College's vision and essential actions for each priority. Appendices 1 to 2 summarises the vision and essential actions by responsible organisation and Appendix 3 presents the methodology and sources used for costing.

Within this paper, we purposefully include mental health policy proposals across all NHS workstreams, following the structure of the Long-Term Plan and maximising the opportunity for system-wide leadership and collective responsibility. However, given the scale of the transformation required over the next decade, the College recommends that NHSE's Mental Health team retain oversight over the mental health programme but explore options for joint governance arrangements, which is presented in more detail in Chapter 14.

FIGURE 1 RCPSYCH'S PROPOSALS FOR CHANGE, 2019-2029

Prevention, Personal Responsibility and Health Inequalities
• 90% of people with severe mental illnesses have physical health checks in primary care
• 20% reduction in national suicide rate
• Everyone who uses mental health services will have equitable access to effective early interventions and equitable experiences of care and outcomes, regardless of age or ethnicity

Healthy Childhood and Maternal Health
• 100% of antenatal classes include information about mental health and parenting
• 70% of children and young people with a mental health problems access treatment/support

Primary Care
• 50% of people with anxiety and depression access psychological therapies each year
• Social prescribing available in primary care

Mental Health Care in the Community, Hospital and Other Specialist settings
• 85% of people having a 1st episode of psychosis start treatment within 2 weeks of referral
• 100% of specialist EIP provision is NICE-concordant
• 100% of acute hospitals have access to Core24 liaison mental health teams

Intellectual Disability and Autism
• 100% of STP areas have GP-held registers for intellectual disability and autism
• Community services for adults and children with intellectual disabilities significantly enhanced

Care for People with Long-Term Conditions and Older People with Frailty
• Mental health support for people with long-term conditions available to all, including but not limited to IAPT
• All mental health trusts create a diabetes register
• 90% of older adults with dementia are offered post-diagnostic support

Cardiovascular Diseases, Respiratory Diseases and Cancer
• The commissioning of services specifically consider psychological needs from the outset
• Appropriately skilled mental health professionals work within those services

Workforce, Training and Leadership
• *Stepping Forward* is implemented in full by 2020/21
• An additional 70,348 staff will be employed in mental health services by 2028/29. From these staff, 4,218 will be psychiatrists

Clinical Review of Standards
• 60% of mental health trusts rated as good/outstanding on safety
• 90% of mental health trusts rated as good/outstanding for being well-led
• 80% of mental health trusts rated as good/outstanding for effectiveness

Digital and Technology
• 100% of mental health settings can use telepsychiatry
• IT systems interoperable between all health providers
• Care pathway following detention under the Mental Health Act 1983 is digitised

Research and Innovation
• Fair, equitable funding of mental health research drawing on the ROAMER priorities
• 50% increase in Clinical Senior Lecturer posts

System Architecture
• 100% of ICSs/ICPs have mental health reflected as a top priority
• End the use of unaccountable block contracts and move to outcomes-based payments
• Routine collection and reporting of patient outcome measures
• Greater transparency and public accountability for the delivery of the FYFVMH and the Long-Term Plan

Fair Funding
• Between 2019/20 and 2023/24, invest an additional **£6.198bn** in mental health services
• Between 2024/25 and 2028/29, invest an additional **£7.456bn** in mental health services
• Commit to a 5.5% to 6.8% funding uplift for mental health above inflation up to and including 2023/24

2. The NHS in 10 years' time

This chapter considers what the NHS might look like in 10 years' time, taking into account population growth and the associated incidence and prevalence of mental illness in the population. Consideration has also been given to morbidity and mortality rates, as well as the utilisation of health services.[5]

Population growth, incidence and prevalence of mental illness

The population of England is growing. The birth and death rates combined with estimates of migration suggest that between 2018 and 2029 there will be around 4.1 million (+7.4%) more people living in the country (Figure 2).[6] Invariably, this will lead to greater demand across public, independent and third sector services and therefore the requirement for additional funding to support that growth.

Mental illness remains one of the largest single causes of disability in England.[7]

- Up to one in five mothers suffers from depression, anxiety or psychosis during pregnancy or in the first year after childbirth.[8]
- Most recent data from 2004 showed at least one in 10 children aged 5−16 have a diagnosable mental health problem.[9] The forthcoming survey is expected to show a substantial increase in the prevalence of mental health problems in young people.
- One in six adults has a common mental disorder.[10]
- 1−2% of adults have a severe mental illness (SMI).[11]
- One in 30 adults is living with a drug dependence.[12]
- One in five older people in the community and two in five within care homes are affected by depression[13] which is often triggered by, and worsening the outcomes for, comorbidities.
- There is an estimated prevalence of 781,000 people in England with dementia as of 2018.[14]
- Evidence suggests the prevalence of all mental disorders is higher in people with intellectual disabilities than in the general population.[15]
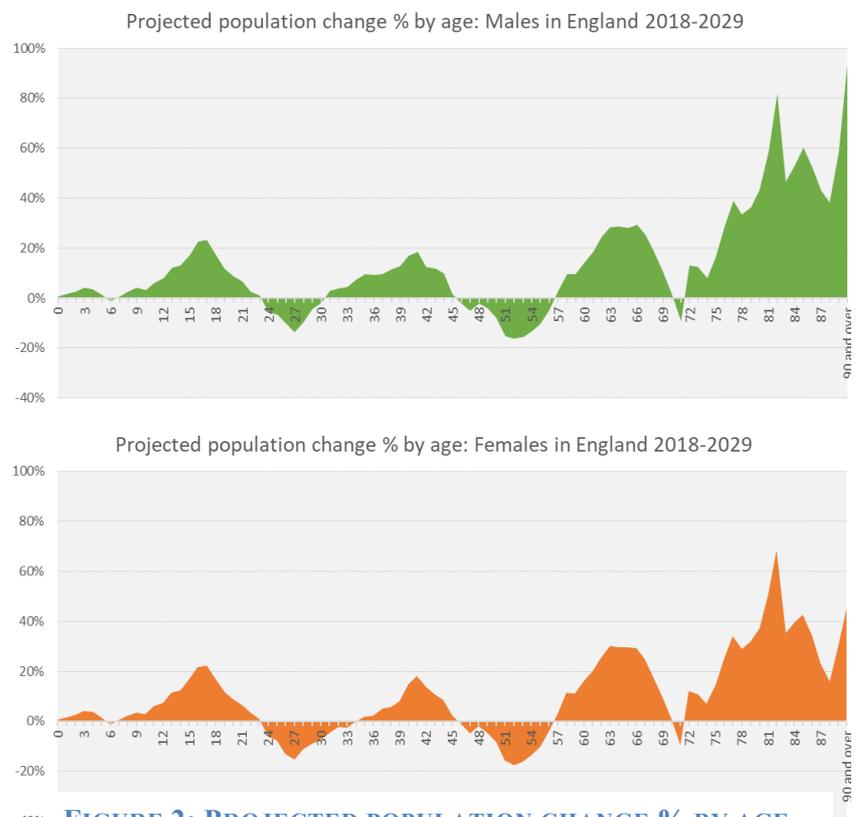
FIGURE 2: PROJECTED POPULATION CHANGE % BY AGE, ENGLAND, 2018-2029

The mental health impact of caring for someone with these illnesses is considerable.

Gender and age are key drivers of demand for health and care services.

More children and young people in the population suggest capacity will need to be increased for child and adolescent mental health services (CAMHS), parenting programmes, self-harm, substance misuse and Criminal Justice liaison services. Early diagnosis and support will also be needed for children and young people with neurodevelopmental disorders.

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More people aged 30−45 suggest a greater demand in the future for Improving Access to Psychological Therapies (IAPT), maternal wellbeing, workplace wellbeing and early intervention services. Furthermore, people with intellectual disabilities are living longer than before, and children born prematurely are surviving, which will have an impact on services in the future.

More older adults, including the very old, means that there will be an increased need for capacity in dementia, old age psychiatry and social care support services. There are clear demographic and economic imperatives to focus much more rigorously on the mental health of older people. The increase in numbers of older people also highlights the lack of research in the treatment and management of depression and other functional illnesses in older adults.

A reduction in the population in their 20s and 50s could indicate that resource could be shifted from some adult mental health services to other areas, or invested in prevention and early intervention services, to offset some of the increased demand.

Applying these demographic changes to the current age-gender profiles of mental health patients in each care cluster provides a more detailed estimate of where increased demand for specialist adult mental health services may present over the next 10 years (Figure 3).[16] Given the projected growth in the elderly population, significant increases in demand are estimated across clusters 18−21 (cognitive impairment and dementia). Another notable growth is expected in common mental health problems/mild non-psychotic disorders and for patients with severe psychotic depression.
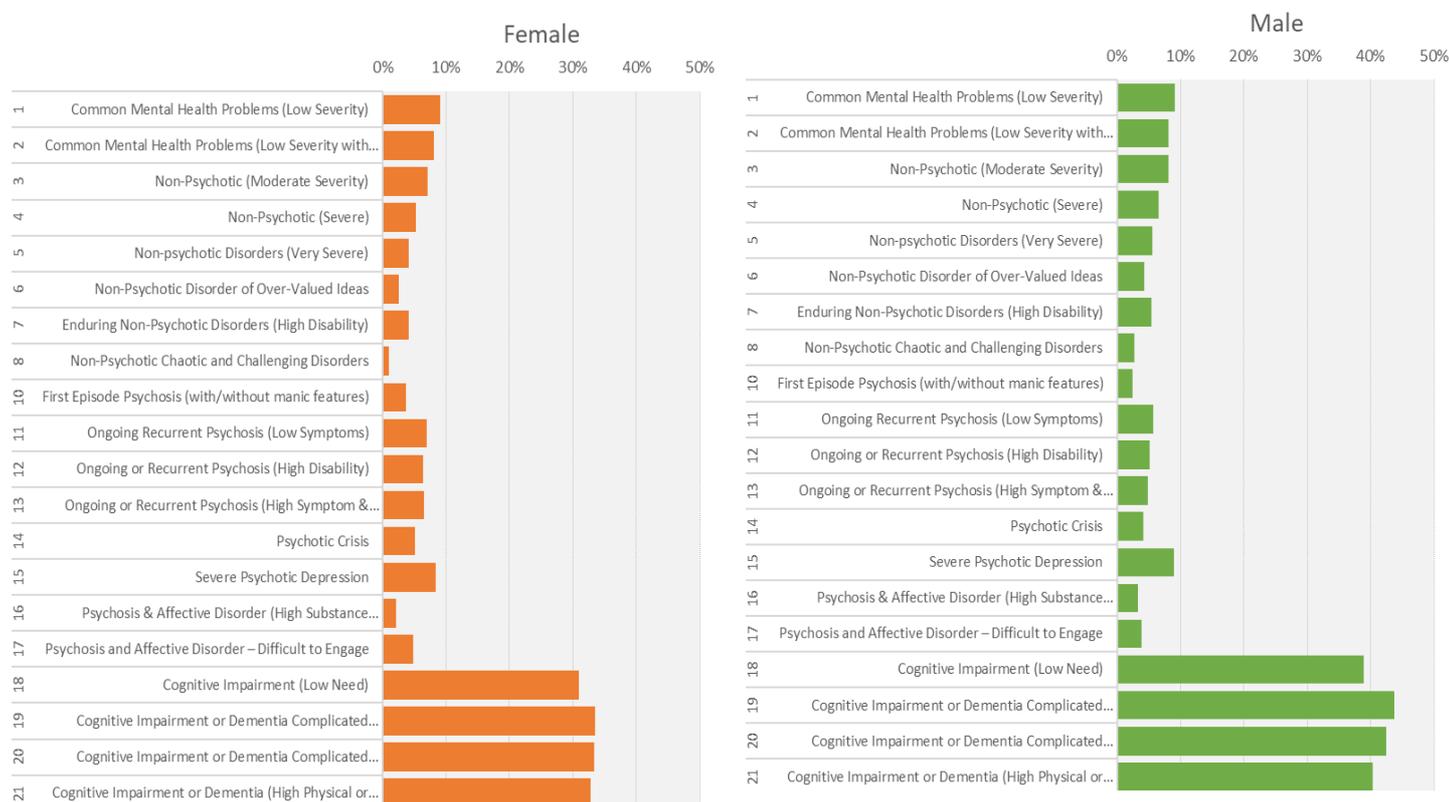
FIGURE 3 ESTIMATED PERCENTAGE GROWTH IN CARE CLUSTER CASELOADS IN ENGLAND (MALE AND FEMALE), 2018-2029

Dementia prevalence and incidence

The likely long-term growth in dementia incidence and prevalence across England is also substantial. Researchers commissioned by the Alzheimer's Society have projected that between 2018 and 2029 there could be an extra 312,000 people living with dementia in England. It could be estimated that, based upon 2014 estimates of late-onset symptom severity, around 173,000 people would have mild dementia, 100,000 would have moderate progression and 39,000 would have severe symptoms of the disease.[17]

Recent estimates indicate each dementia patient costs between £26,000 and £55,000 to manage annually (depending on the severity of disease and whether they live at home or in care) in direct healthcare, social and informal care. Research undertaken for the Alzheimer's Society found that in 2014 the total estimated cost of dementia in England was £22.8 billion. Based on its projections, the increase in societal costs between 2018 (£25.18bn) and 2029 (£35.23bn) would equate to approximately £10.05bn.[18] If the current breakdown of costs remained constant, the overwhelming majority would be comprised as shown in Figure 4.

FIGURE 4: DISTRIBUTION OF FUTURE ADDITIONAL COSTS OF DEMENTIA IN ENGLAND BY 2029

Morbidity and mortality

Based on data from 2012/13 to 2014/15, the gap in life expectancy in England is 19 years and 16 years respectively for male and female mental health service users when compared with the rest of the population (Figure 5). Prior to this, the gap had only reduced marginally over the preceding 7−8 years.[19]

Users of specialist mental health services are more likely to die from any physical health causes than the population who do not require specialist mental health support and management (Figure 6). Many of these 'excessive' deaths could be prevented or delayed by the more widespread use of evidence-based interventions (e.g. health checks and extended lifestyle support, medicine reviews, community falls prevention).
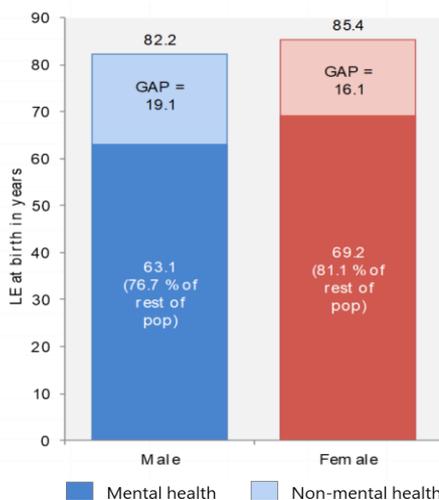
FIGURE 5: LIFE EXPECTANCY FOR MENTAL HEALTH SERVICE USERS COMPARED WITH NON-MENTAL HEALTH POPULATIONS, 2012/13 TO 2014/15 POOLED.
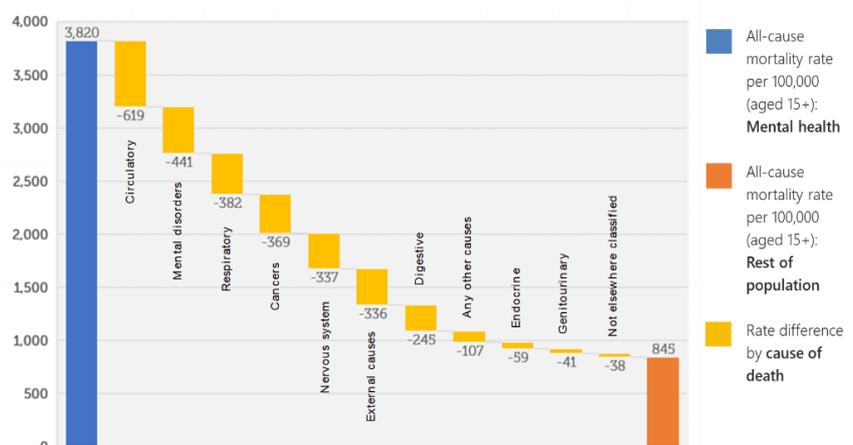
FIGURE 6: CAUSES OF DEATH FOR MENTAL HEALTH SERVICE USERS COMPARED TO THE REST OF THE POPULATION.

The utilisation of health services

Population sub-group	% of England population (15+)
All mental health service users	**7.0%**
Cognitive impairment including dementia	1.8%
Psychoses	1.8%
Personality disorders	0.2%
Common and other mental health	1.8%
Mental health, unassigned	1.5%
Rest of population	**93.0%**
Acute physical health services only	44.2%
'Well population' (no acute demands)	44.8%

Acute healthcare point of delivery	% utilised by mental health service users
Accident & Emergency attendances	**17.2%**
Non-Elective admissions	**23.7%**
Elective (overnight) admissions	**8.9%**
Elective (day case) admissions	**8.1%**
Outpatient attendances	**9.3%**
Diagnostic imaging	**13.0%**

FIGURE 7: PROPORTION OF ENGLAND POPULATION AND ACUTE HEALTH POINT OF DELIVERY

Adult and older adult mental health service users utilise acute emergency (healthcare) services disproportionately – 7% of the adult (over 15) population in England utilise mental health services, but 17% of all A&E attendances and 24% of all non-elective inpatient admissions are for patients who are also mental health service users (Figure 7).

The difference in spend on a subset of A&E and inpatient activity for mental health patients compared to the rest of the population suggest there are significant opportunities to reduce spend on potentially avoidable emergency care – nationally around £65m on A&E and £1.4bn on inpatient services.[20]

There is also a wealth of evidence indicating increased use of A&E by adolescents: for example, a 49.2% increase in finished admission episodes for self-harm and self-poisoning combined among under-18s between 2006/07 (12,980) and 2016/17 (19,370).[21]

Given the demographic projections over the next 10 years, further investment in mental health services is essential to account for rising demand. Chapter 3 considers the progress made by the ALBs, services, NHS trusts and systems since the publication of the FYFVMH, and the lessons that should be learned for the Long-Term Plan.

3. Progress Since the Five Year Forward View

This chapter considers the progress made since the publication of the FYFV in terms of policy implementation, service improvement, the position of mental health trusts, and systems. This should be taken into consideration when developing the Long-Term NHS Plan.

Policy implementation

The FYFV sets out a clear direction for the NHS. It shows why change is needed and what it will look like between 2015 and 2021 if the NHS is able to achieve the triple aim and close three widening health gaps: health and wellbeing, care and quality, and funding and efficiency.

The FYFVMH, published in February 2016, set out a clear and unarguable agenda for the reform of mental health care. The strategy it proposes, built around the evidence and opinion of the thousands of people who contributed to its development, aims to significantly increase the availability and quality of care and treatment for people with mental health problems.

Two years in, there have already been remarkable improvements to the availability and quality of services provided to patients, namely in children and young people's eating disorder services, perinatal services and IAPT services. The building blocks that underpin these policy changes (workforce, funding, data, etc.) have been set up but they are fragile and remain susceptible to in-year planning and operational changes. The Long-Term Plan must go further to hardwire these building blocks into the wider system.

From the College's perspective, four major challenges remain:

1) The mental health workforce plan came too late in the planning cycle and there are now significant difficulties in translating this into action at a local level, which is having an impact on the delivery of the mental health programme.
2) There has been some doubt at a local level as funding transitions into CCG baselines, particularly with regard to the required spending uplift and demonstrating return on investment. The Mental Health Investment Standard has been successful in driving growth in mental health spending overall and this needs to continue to be assessed and assured at a CCG level.
3) Improving the quality and flow of data remains critical, particularly for older adults and children and young people's services. The capacity and capability of NHS Digital (NHSD) to meet the recommendations for a 'data revolution' within this timeframe should be reviewed.
4) Joined-up leadership and governance across Government departments have not been in sync with the governance systems set up within NHSE. The next strategy should go further to align these processes more strategically, presenting opportunities to identify solutions to shared challenges that might lie outside the NHS.

Despite these challenges, in the context of continuing financial and operational pressures, mental health has continued to be reaffirmed as an organisational priority across Government and the NHS, which is commendable.

Service improvements: strengths of the FYFVMH

The introduction of the first ever waiting time standards for mental health means there are increasing numbers of people now accessing treatment and support, with an estimated 2.7 million people in contact with NHS-funded secondary mental health, intellectual disability and autism services in England during 2016/17.[22]

If implemented in full, the recommendations of the FYFVMH will get the NHS some way towards parity of esteem by 2021:

- 30,000 more women each year will be able to access evidence-based specialist mental health care during the perinatal period
- 70,000 more children and young people will be able to access appropriate mental health services
- 600,000 more adults and older adults with common mental disorders will have access to the IAPT programme
- 60% of people experiencing a first episode of psychosis will be treated within a National Institute for Health and Care Excellence (NICE)-approved treatment pathway within two weeks
- 280,000 more people living with mental health problems will have improved physical health
- At least half of all acute trusts will deliver 'core 24' liaison psychiatry for adults
- The number of people who die by suicide will be reduced by 10%
- All inappropriate out-of-area placements (OAPs) for acute care will be eliminated, and
- 100% of the population will be able to access liaison and diversion services.[23]

Nationally, 67.7% of people living with dementia have received a formal diagnosis; a national standard that has been consistently achieved since July 2016 and exceeds the target of 66.7%.[24]

There is a delicate balance between celebrating progress made so far and recognising the challenge that remains to address the unmet need for mental health care.

Service improvements: weaknesses of the FYFVMH

'Core' vs 'transformational' services

The FYFVMH focused heavily on select, predominantly specialist, areas of services (e.g. community perinatal mental health services, community eating disorder services for children and young people and IAPT). Whilst these specialist services rightly deserved attention, it came at the expense of other equally important areas. This particularly affected the historical 'core' mental health services. This is symbolic and symptomatic of long-term neglect. Yet it is within these very core services that the vast majority of mental health care is delivered for those with severe problems. They also tend to interact with the length and breadth of the wider system, including more specialist areas. For example, while there has been a much-needed focus on early intervention in psychosis (EIP), there has not been an equal emphasis on care for people with longer-term psychosis and SMI.

Therefore, as we have seen from previous reforms that have looked to replace community mental health services with specialist provision; the National Service Framework (NSF) introduced Crisis, Assertive Outreach and EIP teams; the FYFVMH expanded perinatal, liaison, eating disorder services: this can only go so far, or the service becomes too fragmented and consequently not patient-centred.

'All-age' services

The FYFVMH paid little attention to mental health services in the community, where most secondary mental health care is provided, including for older adults. As a result, the services advocated were not distinguished from those for working age and those for older adults. This had the unintended consequence of resources being funnelled into services such as crisis resolution teams and with a few exceptions, these only work with the working age population.

As such, the longstanding funding disparity between adult and older adult mental health has continued. Older adult mental health services risk being left behind if funding uplifts are preferentially targeted toward working age adult-focused services. Given the large and growing proportion of older adults with mental illnesses and the high morbidity and costs associated with poor treatment, old age mental health services are essential.

Likewise, the focus of CAMH services is almost wholly focused on children and young people in crisis, which comes at the expense of earlier intervention with children and young people that need support but

have not yet fallen into crisis. There has also not been an increase in provision for the early years, in particular, parenting and early diagnosis for neurodevelopmental disorders and support.

Missing groups

In addition, five population groups were excluded from the FYFVMH strategy:

1) Older adults with functional and organic mental illnesses
2) Those living with substance use disorders
3) Those with neurodevelopmental disorders
4) People with complex needs such as personality disorder/emerging personality disorder, and
5) People with intellectual disabilities and autism.

For intellectual disability services, in particular, the parallel Transforming Care Programme will end in March 2019 and uncertainty remains about the future of the Programme.

The exclusion of these groups has had a perverse and unintended consequence on healthcare planning and delivery. The lack of focus on the specific and distinct needs of these groups sent a message that these were not areas which needed investment or reform. As they were also not considered 'FYFVMH or transformational' areas, they received no uplift in Health Education England's (HEE) mental health workforce plan for England, *Stepping Forward to 2020/21*.[25]

NHS trusts' financial positions

Improvements to mental health services over the past three years should be seen in the context of the financial and operational performance of mental health trusts. From the last quarterly performance report for NHS trusts and foundation trusts in 2017/18, income for mental health services amounted to £8.418m, £70m (0.8%) below plan. This can be compared to income for community services (physical health), amounting to £7.406bn, which was £338m (4.8%) above planned levels.[26]

Yet mental health trusts are, overall, financially stable organisations with a posted overall surplus of £297m in 2017/18, compared to a planned surplus of only £125m. Only six trusts posted a deficit, which, at 11.3%, was only bettered as a proportion by ambulance trusts (0%).[27]

Posting a surplus year-on-year is favourable but it is somewhat of a misnomer: it is underspending. As block contracts is the payment system predominantly used by mental health trusts, it discourages providers from increasing their activity to meet demand and disincentivises accepting patients with more complex needs. In contrast, the acute sector use payment by results (PbR), a case-based payment system with nationally set prices for units of care that apply across providers. This system incentivises increases in activity to meet demand while also improving efficiency.

Given the nature of these different payment systems – one incentivising more activity, the other not – it would be wrong to assume that the presence of surpluses in mental health trusts means they did not need the money in the first place.

Looking at the £1.783bn sustainability and transformation funding (STF) in 2017/18, mental health trusts received 11.78% (£210.06m) compared to 8.81% of a slightly larger pot (£1.796bn) in 2016/17. While only receiving 8.1% of the core STF allocation, mental health trusts fared better in the allocations of 'financial and performance incentive STF' (£62.7m of £349.5m, 18%) and bonus STF (£52.5m of £198.9m, 26.4%). Mental health trusts represent 23% of the total in NHS Improvement's (NHSI) categorisation (53 of 234).

Furthermore, while capital expenditure was ultimately below planned levels across the board, it was within mental health trusts that the shortfall was greatest in percentage terms. Capital spend amounted to only

£280m in 2017/18, 38.9% below the planned £458m. This compares to 29.1% below planned spend across all trusts, 28.9% within non-specialist acute trusts and 26.3% for community trusts.[28]

Overall, mental health trusts are financially stable organisations, but received less income than planned, meaning their capacity to respond to increasing demand, as well as addressing crucial estate and capital plans, is hindered.

System planning and delivery

The quality of mental health plans produced by Sustainability and Transformation Partnerships (STPs) has been variable. Although the scale of transformation required to expand and integrate mental health services should not be underestimated, there is a lack of guidance on the best way to do this at a 'place-based' level in an organisationally-agnostic way. This is a major barrier.

Through the College's work with The King's Fund, we concluded that while many of the 'vanguard' sites included some mental health components in their care models, with several reporting promising early results, the full opportunities to improve care had not been realised.[29] Further, areas joining together to form Integrated Care Systems (ICSs) and Providers (ICPs) provides a chance to accelerate mental health integration with primary care, specialised commissioning and social care, removing perverse incentives and driving improvements in mental health outcomes.

STPs and new models of integrated and accountable care need to address outcomes that are important to patients, carers and the public, as well as outcomes that are desirable for the workforce and the wider system. But we know any form of engagement in the STP or new care model process is variable across the country. With greater buy-in from the workforce, it will be easier to make the desired changes at the necessary pace and scale.

In light of these developments over the past 2-3 years, Chapters 4 to 16 set out the College's vision and essential actions for each of the Long-Term Plan priorities in detail.

4. Prevention, Personal Responsibility and Health Inequalities

As a patient:
I can access support appropriate to me, regardless of my age, ethnicity or sexuality to keep me physically and mentally well, from services designed with people with lived experience. I feel empowered to shape my own care and my physical health concerns are taken seriously and acted on, in any setting.

As a clinician:
My organisation prioritises keeping people mentally and physically well. Mental health and wellbeing is considered throughout all of my work and right across all services I work with. Patient outcomes are monitored to identify where and how improvements can be made. I have received training that has given me the confidence to address factors that result in health inequalities and how to keep people in good physical and mental health.

This chapter sets out proposals for tackling inequalities in mental health provision, preventing poor physical health and premature mortality in those with mental health problems, including preventing suicide and learning from deaths. Finally, this chapter considers proposals to embed mental health into population health management approaches.

Tackling inequalities in mental health provision

Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. Across England, there are persistent and wide-ranging inequalities for people from Black, Asian and minority ethnic backgrounds, increasing their likelihood of being disadvantaged across all aspects of society compared to those from other backgrounds. As the Equality and Human Rights Commission has highlighted, an individual from a Black, Asian and minority ethnic background is more likely to experience poverty, to have poorer educational outcomes, to be unemployed, and to come into contact with the criminal justice system.[30] These, in turn, are risk factors for developing a mental illness.[31] These individuals are also less likely to receive care and support when they need it. Racism and racial discrimination are one of many factors which can have a significant, negative impact on a person's life chances and mental health. The College is particularly concerned about the disproportionate impact on people from Black, Asian and minority ethnic communities, notably those of Black African and Caribbean heritage.

As the College has previously recognised, patients in the NHS may experience racism and racial discrimination.[32] [33] This has also been recognised as a problem in international healthcare systems.[34] It can lead to substantial disparity in access to and experiences of various areas of psychiatric care, including crisis care[35], admissions[36], detentions[37], pathways into care[38], readmission[39] and use of seclusion[40]. The 2014 Adult Psychiatric Morbidity Survey[41] showed that, although Black British adults had the highest mean score for severity of mental health symptoms, they were the least likely to receive treatment for mental illness. Where they do come into contact with services, it is disproportionately based on a detention order requiring them to stay in hospital.[42] Efforts to tackle this should be urgently prioritised by the Government, non-governmental organisations and professional bodies.

Furthermore, ageism and age discrimination are commonplace. Due to unconscious bias and perceptions, older adults can experience discrimination leading to less accurate diagnosis and treatment, which in turn causes harmful consequences. Older people with mental health problems in England often do not receive the same level or quality of mental health care as those of working age, and these services have been excluded from new investment.

Vision

➤ By 2023/24, everyone who uses mental health services should have equitable access to effective early interventions and equitable experiences of care and outcomes, regardless of age or ethnicity.
➤ By 2023/24, there will have been a year-on-year reduction in the disparities between people from Black, Asian and minority ethnic groups and the rest of the population, in terms of both numbers of people detained under the Mental Health Act 1983 and the range of appropriate treatments offered including alternatives to detention.
➤ By 2023/24, LGBTQ+ services are expanded as well as outreach services to deprived children, young people and families, hard to reach groups and those from Black, Asian and minority ethnic communities.
➤ By 2023/24, people at risk of discrimination, and protected groups under the Equalities Act subject to the Mental Health Act have access to an advocate with specialist knowledge of legislation to advocate appropriately for them.
➤ By 2023/24, mental health tribunal panels better reflect the communities they work with.

Essential actions

• DHSC to appoint a team of equalities champions with a specific remit to tackle mental health inequalities across the health system and through cross-Government action.
• Government to introduce an obligation in primary legislation to reduce inequalities, including amending the statutory duties placed on CCGs, NHSE, local authorities and the Secretary of State. This should include:
    o an explicit requirement to assess the gap between people with mental health problems across the spectrum accessing health and care services and the rest of the population
    o a plan to improve and/or integrate services to close this gap year-on-year, and
    o an explicit requirement on the Secretary of State for Health and Social Care to assess how well NHSE has fulfilled these legal duties and respond publicly each year.
• DHSC to commission high-quality research on the impact of racism on mental health in line with a national research priority-setting exercise.
• DHSC to work with other government departments, professional bodies (including the medical Royal Colleges), charities, patients and carers to raise literacy on the impact of racism and ageism on mental health, and to provide leadership in implementing preventive interventions and actions.
• DHSC to establish a 'Health and Social Care Observatory' to monitor, track implementation and report on the impact of policy and practice on the mental health of patients, including Black, Asian and minority ethnic groups.
• NHSE to prioritise the implementation of the patient and carer race equality standard currently being developed by the National Collaborating Centre for Mental Health (NCCMH). This should include setting up monitoring and reporting processes for all trusts.
• NHSE to work with the medical Royal Colleges and other organisations to ensure that health and care professionals receive diversity and equality training and promote effective training for NHS organisations to monitor and address factors that put Black, Asian and minority ethnic groups at a disadvantage.
• With support from commissioners and other partners, mental health trusts, and other trusts providing mental health services across England should involve people from Black, Asian and minority ethnic groups as well as older people in all aspects of their organisation, including service co-production, planning and delivery of care. They will need to ensure that patients involved in these activities receive appropriate training, development and support.
• The Government to ensure all government policies, whether new or existing, are assessed for their impact on mental health with findings published ahead of any changes being made and revisited every 2 years.

Preventing poor physical health and reducing premature mortality

Improving the physical health of people living with a mental illness should be an urgent priority. The evidence is clear: poor mental health is associated with other priority public health challenges such as obesity[43], lack of exercise[44], alcohol misuse[45] and smoking.[46]

Approximately 50% of patients on the Quality and Outcomes Framework (QOF) registers received the full set of health checks in 2016/17. Accounting for growth in QOF disease registers (average 3.5% annually between 2006/07 and 2016/17)[47] there may be 800,000 patients managed on SMI (Mental Health) registers by their GP by 2028/29. However, there has been no published CCG or STP level data relating to physical health checks or premature mortality rates since 2014/15.

In addition, there is no requirement for CCGs to commission services delivering physical health assessments for patients with severe enduring eating disorders (SEED) because they are not classified as having an SMI. Those patients present with a combination of severe symptoms and long-term illnesses and may experience serious chronic physical sequelae (e.g. osteoporosis and renal failure), marked social isolation and stigma. Their carers also suffer from the stress of caring for their multiple, complex needs over a prolonged period.[48]

Vision

➢ By 2028/29, 90% of people on the SMI primary care register will receive physical health checks (727,312) in primary care.

Essential actions

- NHSE to urgently work with NHSD to review the data collection for excess mortality and commit to a quarterly publication.
- NHSE to include severe and enduring eating disorders (SEED) in the SMI register. CCGs to then commission services that deliver comprehensive physical health assessments and follow up care to people with SEED.
- DHSC to support and resource the 'Equally Well' initiative, which will be producing a Charter for Equal Health in autumn 2018.

Preventing suicides and learning from deaths

There were 4,451 people who took their own life in England in 2017, a 2.7% reduction compared to 2016. The standardised rate also declined by 3.2% (from 9.5 to 9.2 per 100,000) in comparison to the previous year. Around three-quarters of all suicides in 2017 in England were male.[49]

DHSC, Public Health England (PHE) and NHSE asked all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10% reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide and include a strong focus on primary care and substance use disorders.

Vision

➢ A 20% reduction in the national suicide rate between 2021/22 and 2028/29.
➢ Continue with the aspiration for 'zero suicides' in NHS inpatient settings among people receiving specialist mental health care.
➢ By 2023/24, all NHS trusts can identify deaths that warrant an investigation and put in place a process to learn from them in cases where a patient had been receiving treatment and support for their mental

illness, with a particular focus on people 'at risk' such as those who are from a Black, Asian and minority ethnic groups.

Essential actions

- Every local area to produce an annual suicide prevention plan assessed against assurance measures to be developed by PHE, DHSC and the Ministry of Housing, Communities and Local Government (MHCLG) and report on their progress to reducing suicides at the end of each year. This should be overseen by a national implementation board.
- NHSE and PHE to implement and resource a self-harm and suicide prevention competence framework, due to be published in 2018, for a wide range of professionals working in education, police and housing.
- NHSE to roll-out the 'Learning from Deaths' tool produced by the College's Centre for Quality Improvement (CCQI), which support trusts to respond to concerns about any aspect of their care; and provides trusts with guidance on using individual reviews to consolidate learning identified using the tool. RCPsych will collate reviews, perform thematic analyses to identify learning points, and report these back nationally.

Population health management

More should be done to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at-risk groups such as children and older adults.

There should be a focus on public mental health and wellbeing within population health management approaches, recognising the role of poor mental health as a major risk factor for many other conditions. This should include work on perinatal mental health, children and young people (where some of the greatest opportunities for prevention lie), and on wider services such as addiction, homelessness or housing services and employment support.

In some areas of the country, population health management approaches involve understanding health inequalities and health service utilisation by creating a linked dataset with patient-level information from acute services, primary care, primary care prescribing, mental health, community services, continuing healthcare, social care, public health and specialised commissioning. Using these data can help clinicians to redesign pathways and services, and to understand the quality, strategic, commercial and financial opportunities and risks of a capitated approach to contracting.

Vision

- ➢ All STP/ICS/ICP leaders to employ population health management approaches with sufficient consideration for mental health and wellbeing.
- ➢ All STP/ICS/ICP leaders to develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners' collective ambition for improving outcomes for people living in the area, which should be then used to monitor performance against the outcomes framework annually.

Essential actions

- NHSE and local leaders to publish national and local evaluations of new models of care (vanguard sites), including an assessment of their impact on people with mental health problems as well as on mental health and wellbeing-related outcomes across the wider population.
- NHSE to provide local systems with guidance and examples of good practice, demonstrating how population health approaches can help address mental health issues as well as wider public health problems.

Healthy new towns

There are 10 housing developments across England that are seeking to shape the health of their communities and to rethink how health and care services can be delivered on NHS land.[50]

For example, on old Ministry of Defence brownfield land in Hampshire, Whitehill and Bordon are building 3,350 new homes, a new town centre with new leisure centre, secondary school, cinema and health hub and 80 hectares of suitable alternative natural greenspace. They are seeking to reduce the incidence of poor mental health through their plans with better access and connectedness of health services and a better-built environment. The project will be complete by 2036.

Similarly, on a greenfield site in Bicester the council are building 13,000 new homes and using the opportunities presented by population growth to test innovations in the built environment, new models of care, and community activation to identify the impacts they have on public health and to replicate the learning elsewhere. The key priority for Bicester is to reduce the number of people who feel socially isolated or lonely and improve their mental wellbeing.

Vision

➢ By 2028/29, all 'Healthy New Towns' to include within their plans a priority to promote good mental health and wellbeing of their population and improve access to health services for people of all ages with mental ill health. Dementia-friendly communities should be a fundamental part of the design.

Essential action

• NHSE and PHE to require all 'Healthy New Towns' to report on their progress to promote mental health and wellbeing (amongst other priority areas) annually and take action accordingly.

This chapter has described proposals for tackling inequalities in mental health provision, preventing poor physical health and premature mortality and ways to embed mental health into population health management approaches. The next chapter considers mental health proposals for good maternal and child health.

5. Healthy Childhood and Maternal Health

> **As a patient:**
> Support for mental development and health alongside physical health is available from conception onwards with access to linked, multi-agency services for parents and children both through universal services and specialist services where appropriate.
>
> **As a clinician:**
> I am confident to support all children and their parents to ensure that they have the best start in life and ongoing development, regardless of their circumstances. All my colleagues and I are trained to be able to identify the mental health needs of vulnerable children and know how to support or signpost appropriately.

This chapter sets out proposals for perinatal, parental and early years mental health services, as well as children and young people's mental health services.

Perinatal, parental mental health and early years mental health services

Vision

- ➤ By 2023/24, expand perinatal and early years mental health services within Universal Services (maternity services, health visiting, Sure Start centres and primary care).
- ➤ By 2023/24, antenatal classes should universally include information about mental health and wellbeing, as well as parenting, and Parenting Programmes.
- ➤ Between 2021/22 and 2028/29, Community Perinatal Mental Health Services should continue to support women in the perinatal period and increase the paternal mental health support made available.
- ➤ Between 2021/22 and 2028/29, maintain the same access rate to evidence-based specialist mental health care for women with an SMI during the perinatal period as is planned for the end of the FYFVMH. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

Essential actions

- DHSC, MHCLG, NHSE, PHE and HEE to develop a national Perinatal, Parental Mental Health and Early Years Mental Health Strategy.
- DHSC and MHCLG to provide greater investment in support for teenage mothers and their children, given the high rates of mental health problems in teenage and young mothers.
- NHSE to develop services for pregnant and postnatal women with underlying personality disorders, and services for women with substance use disorders.
- NHSE to ensure CCGs sustain their investment in new/existing specialist community perinatal mental health teams developed during the FYFVMH period.

Children and young people's mental health services

Vision

- ➤ By 2023/24, 45% and by 2028/29, 70% of children and young people with a diagnosable mental health condition will be accessing integrated treatment and support, through IAPT, Mental Health Support Teams in schools, and CAMHS with appropriate waiting times.

➢ By 2028/29, an equivalent model for Crisis Resolution and Home Treatment Teams (CRHTTs) will be developed, which should be multi-agency (including social workers) and adapted to meet the needs of children and young people.

➢ By 2028/29, a 4–6 week waiting time will have been implemented for access to specialist NHS children and young people's mental health services, building on the expansion of specialist NHS services already underway.

➢ By 2028/29, there will be developmentally informed services for children and young people up until the age of 25 years, and this should be appropriately resourced between child and adolescent and adult mental health services.

➢ By 2028/29, every school and college will have identified a Designated Senior Lead for Mental Health to oversee the whole-school approach to mental health and wellbeing.

➢ By 2028/29, all Mental Health Support Teams will have received training to be equipped with the ability to identify the mental health needs of vulnerable groups of children and young people – such as young people not in education, employment or training (NEETs), children with neurodevelopmental problems (including Attention Deficit Hyperactivity Disorder [ADHD], autism spectrum disorders [ASD] and intellectual disabilities), children with long-term health conditions, children with behavioural difficulties, looked-after-children, young carers, refugees and migrant children, children with a first language other than English, children in the criminal justice system, abused children, LGBTQ+ young people – and to refer them appropriately.

Essential actions

•   DHSC working with the Department for Education (DfE) to implement the proposals in the Children and Young People's Green Paper in full, and the forthcoming prevalence survey should be reviewed and taken into consideration. DHSC and DfE should view this as a starting point and commit to building a more ambitious second phase.

•   DHSC to develop a new model of support for looked after and previously looked after children.

•   NHSE to review the availability of services for children and young people with neurodevelopmental disorders and their families, from early diagnosis and post-diagnostic support, through to specialised services and a good transition to a developmentally-appropriate service.

•   NHSE to roll out the New Care Models in Tertiary Mental Health programme to support more appropriate local provision through joint commissioning between NHSE and providers so that children and young people in need of inpatient beds access a bed close to home. Within this programme, children and young people, should not be admitted to tier 4 beds due to lack of appropriate social care provision, including specialised community placements.

•   CQC and other partners to implement the recommendations of their review of children and young people's mental health services in full.[51]

•   CCGs to fund new Mental Health Support Teams in schools, supervised by NHS children and young people's mental health staff, to provide specific extra capacity for early intervention and ongoing help.

•   NHSE to develop a robust integrated pathway of care for children and young people with an intellectual disability and/or autism and a mental health condition, covering services throughout their lifetime. This pathway should focus on strengthening support in the community by building on the provision of preventative support and early intervention programmes (including evidence-based parent training programmes), and a range of support and training for families and carers.

•   The Government to publish an evaluation of how the Green Paper proposals affect vulnerable groups of children.

This chapter has described proposals for perinatal, parental and early years mental health services, as well as children and young people's mental health services. The next chapter considers proposals for mental health treatment and support in primary care.

6. Primary Care

As a patient:
I am confident that I can talk to my GP or any other primary mental health care professional about my mental health issues. I know that I will be treated with compassion, receive support promptly, close to home and in a holistic way. If I need to be referred to a specialist mental health service, my care will not be interrupted.

As a clinician:
I have the resources to provide whole-person care to patients with overt or covert mental health issues. With my team, we work proactively with people at particular risk of mental disorder, people with long-term physical conditions, people with protected characteristics, and carers. We always work collaboratively with other services and can access specialist expertise and to a range of secondary care services as required.

This chapter sets out proposals for primary mental health care, including the IAPT programme.

Primary mental health services

Primary care needs to be enabled to provide a broader range of services in the community that integrate primary, community, social and acute care services, and bring together physical and mental health, particularly for older patients where comorbidity is common. For people with highly complex needs in primary care, some CCGs have integrated care teams covering a local area or 'neighbourhood'. As such, primary mental health services can enable people with stable SMI to be discharged from secondary mental health services. Effective liaison and coordination with specialist mental health services for older adults is a vital aspect of primary mental health care services, given that the majority of patients who use primary care services and have long-term conditions are older adults.

Primary care professionals also have an important role to play in detecting depression and/or cognitive difficulties early in someone with a long-term physical health condition.

Vision

➢ By 2023/24, invest in new forms of mental health support as a central component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice (including among people presenting primarily with physical symptoms), and to address the physical health needs of people with mental health problems. This will need to be done in a way that is aligned with wider efforts to transform primary care to ensure that it is sustainable.
➢ By 2023/24, ensure that local integrated care teams can make full use of mental health expertise in supporting people with complex and ongoing care needs, with mental health staff (community psychiatric nurses, nurse therapists and psychologists), including those with expertise in older people's mental health, enabled to input proactively into all case discussions and offer advice and training to the wider team.
➢ By 2023/24, all primary care services should accept dual GP registrations for students and be able to manage care in a coordinated way.

Essential actions

• NHSE to ensure that mental health is a core component of all work being developed in multispecialty community providers (MCP), primary and acute care systems (PACS) and primary care homes as part of an STP/ICS/ICP.

- HEE to strengthen mental health capabilities in the primary and community health workforce by improving the confidence, competence and skills of GPs (including for children and young people's mental health issues), integrated care teams and others, as well as making the best use of community pharmacists. Similarly, aim to strengthen the physical health competencies of mental health professionals.

IAPT programme

Vision

➤ By 2028/29, 50% of people with common mental disorders can access psychological therapies each year.
➤ By 2028/29, the choice of therapies available in the IAPT programme is expanded across all mental health diagnoses.
➤ By 2028/29, parity of access to IAPT services is delivered for older people (who are significantly less able to access psychological therapies by dint of frailty and multimorbidity) and people with an intellectual disability. Services need to comply with equality legislation by making a reasonable adjustment to their services to facilitate people with an intellectual disability using IAPT services.

Essential actions

- DHSC to ensure equality in the NHS Constitution, as currently, patients do not have the right to access the majority of mental health treatments and therapies, even though they are NICE-approved, because they are not classed as a 'technology'.
- NHSE to review the current exclusion criteria for accessing IAPT services and consider the factors affecting the number of people who do not complete treatment.
- NHSE to develop a strategy to reduce the gap in access between older adults, Black, Asian and minority ethnic groups, students and any other group not currently served well by IAPT services.

Accessing community resources

There has been a growing interest across the country in the use of social prescribing and related approaches to connect people with resources in their local community aimed at improving health and wellbeing. Evaluations have reported positive results in terms of patient outcomes and service use allowing healthcare professionals to refer people to a range of non-clinical services to address their needs in a holistic way and often focuses on improving mental health and wellbeing.

While used predominantly for adults and older adults, children and young people can also significantly benefit from this, particularly during times of transition in their lives (such as leaving home) as lack of activities, isolation and loneliness can cause and exacerbate mental health problems. Similarly, people with an intellectual disability can benefit in order to reduce social isolation and promote inclusion.

Wellbeing coordinators, care navigators and/or Wellbeing Hubs are another way to help connect people with local voluntary and community sector services – particularly people who are at risk of social isolation and need some extra support, or who are known to be experiencing emotional distress. The intention is to prevent the development of mental health problems and to support the recovery of those with existing mental health problems. The aspiration should be to widen the wellbeing offer in primary care over time, with the addition of peer-coaches, self-management courses and (potentially) other resources such as dementia care navigators.

Vision

➤ By 2023/24, primary care services routinely offer social prescribing, where appropriate.
➤ By 2023/24, primary care services employ wellbeing coordinators (or similar) to support people with mental health problems, and other physical health conditions to access community resources.

Essential action

• Every primary care service to extensively map assets and resources within the community, with due consideration of mental health and wellbeing resources. The ease in which patients can access these resources (with a particular focus on excluded groups), and the ease in which primary care professionals can refer to them, should be regularly reviewed.

This chapter has set out proposals for primary mental health care, community resources and the IAPT programme. The next chapter considers proposals for mental health services for those of working age or older adults.

7. Mental Health Care in the Community, Hospital and Other Specialist Settings

> **As a patient:**
> I can access care in the right place at the right time in order to support my mental health needs in a way that is appropriate for me. I am confident that I will be treated with compassion to support me to stay as well as possible and close to home. When I need support for my mental health, people work together, respecting my culture and background, my goals and my experience, to deliver fast access to care which is responsive to my personal needs and close to my home.
>
> **As a clinician:**
> I am able to give the people I care for high-quality support at the most appropriate time and in the most appropriate way, in line with NICE recommendations. This is satisfying as I can help improve patients' lives by supporting them to stay as well as possible rather than firefighting at a crisis point.

Patients have benefited from maximum waiting time targets for physical health care for many years, ensuring they have timely access to care. Historically, treatment options for mental health compare unfavourably with those for physical conditions. The public now rightly expects these service gaps to be addressed.

A modern mental health system means integrated and accountable care, with new working methods across institutional boundaries, that allows the values of the NHS to be better delivered. It takes a holistic, whole-system view of mental health services, and rebalances attention, focus and resources between 'core' (e.g. community mental health and acute) services and 'transformational' areas (e.g. IAPT).

The Long-Term Plan must commit to addressing health inequalities in the round, including but not limited to those people defined as having protected characteristics under the Equality Act 2010, including children from Black, Asian and Minority Ethnic Backgrounds.

This chapter predominantly focuses on the mental health of the working age and older adult population, as other mental health services are incorporated elsewhere in this paper.

Mental health assessment services

The NHS needs to strengthen the mental health components of urgent and emergency care pathways, as well as rebalancing focus and resources to 'core' mental health services for people with severe and enduring mental illness. In light of the Independent Review of the Mental Health Act 1983, it is necessary to consider new or enhanced service models for crisis response and care to reduce the number of people, including children and young people, who need to be compulsorily detained.

Vision

111 and 999 Services

➢ By 2028/29, every STP should have First Response Services (or a similar model) that directs 111 callers to 24/7 support and mental health crisis response. The service should consist of: experienced psychological wellbeing coaches who provide initial assessment via telephone; a coordinator who oversees the coaches and coordinates calls from emergency services; and first responders (mental health nurses or social workers) who provide face-to-face assessment and crisis management.
➢ By 2028/29, every police control room should have a mental health practitioner present in order to improve the care people receive when in contact with the police.
➢ By 2028/29, all areas of the country should use Street Triage service staffed by police officers, paramedics and mental health nurses.

Places of Safety

➢ By 2023/24, end the use of police vehicles to transport people with a mental illness to a place of safety, except in exceptional circumstances.
➢ By 2023/24, end the use of police cells as a place of safety for adults, as is currently the case for children and young people, except in exceptional circumstances.

Liaison Mental Health Services

Most referrals to a typical liaison psychiatry service come from acute inpatient wards and people with complex and severe problems require sustained outpatient specialist input that goes beyond acute admission.

For those with severe and complex problems living with long-term conditions and medically unexplained symptoms, expertise in liaison psychiatry offers an important resource for follow-up, and yet only a quarter of English liaison services offer outpatient clinic treatment for such cases. This lack of resource for an important, complex and costly group of patients is an important area to be addressed.

Vision

➢ By 2023/24, 65% of acute hospitals and/or paediatric departments provide access to a Core24 liaison psychiatry service and 100% by 2028/29. These teams should include psychiatrists with expertise in older adults.
➢ By 2028/29, integrated in and outpatient services include liaison psychiatry to meet the needs of patients with more complex problems.
➢ By 2023/24, 100% of acute hospitals have a protocol for the management of severe malnutrition in patients with anorexia nervosa.

Essential action

• The government, DHSC and NHSE commit to act on the recommendations of the Independent Review of the Mental Health Act 1983 and provide local areas resourcing support as needed.

Community mental health services

Core services form the backbone and foundation of the whole service; if they are struggling, which the evidence suggests they are, then the wider system will inevitably struggle too. Bolstering community and outpatient care for mental health will be essential in meeting the NHS's overarching operational challenges to reduce total bed days, the average length of stay, inappropriate OAPs and delayed transfers of care.

We need to integrate across the 'core' services: community, crisis and inpatient services, with all three functioning effectively for the whole service to work. In recent years, one area has been developed at the expense of the other. This is particularly relevant to the Mental Health Act 1983 review, i.e. better community services mean fewer crises and reduced detentions under the Act.

The work of community mental health services has changed since the last major reform in the NSF in 2000: increased awareness has led to substantial increases in referrals for ADHD, autism, bipolar affective disorder, eating disorders, personality disorders – conditions which require specialist community mental health services assessment rather than treatment via IAPT; social care has been dislocated from mental healthcare because of local authority spending reductions.

Community mental health services include Community Mental Health Teams (CMHT), Access Teams (including single point of access), Community Adult Eating Disorder services, Old Age Community Mental

Health services, Community Rehabilitation Mental Health services, Assertive Outreach teams, and other recovery teams. The majority of care for people with intellectual disability is also provided through community services.

Vision

➢ By 2028/29, 100% of community mental health services are meeting a defined set of recommended NICE guidelines and more staff are able to give continuity of support to a larger number of patients with SMI to prevent relapse, hospitalisation and the use of the Mental Health Act 1983.

Essential actions

- NHSE and NCCMH to publish and implement the findings of their Community Mental Health Services Project.
- NHSE to link co-production and continuity of patient care to payment through CQUINs, with an emphasis on the least restrictive care.
- NHSE to consider the findings from the North-East London Foundation Trust's national multi-centre Open Dialogue pilot.[52]

Rehabilitation mental health services

Vision

➢ By 2023/24, there will be a Community Rehabilitation and Recovery team in every mental health trust and the right complement of Rehabilitation inpatient services in order to avoid the use of 'locked rehab' units.

Essential actions

- The MHCLG, DHSC and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.
- NHSE to ensure every STP has Individual Placement and Support (IPS) services and there is fidelity to the model.

Mental health services for older adults

Vision

➢ By 2023/24, access to mental health support (incl. IAPT) for older people will be on par with services available to working-age adults.
➢ By 2023/24, all settings in which older people with mental health issues are resident will have easy access to a mental health support team that includes the services of a specialist in old age psychiatry.
➢ By 2023/24, a system to be in place for regular communication/cooperation between primary care, old age psychiatric services and social care to synchronise care delivered to older adults.
➢ By 2023/24, social care teams, managers of residential and care homes with nursing, GPs, patients and their carers will have clear pathways for providing initial and continuing care for mental health issues.

Essential actions

- DHSC to develop new models to support older people with mental health issues in the community, moving beyond the model that depends on memory clinics.
- PHE and NHSE to develop a preventative strategy including initiatives to reduce the incidence of loneliness along with other factors that are known to reduce the risk of mental illness in older people.
- CCGs to commission specialist mental health services for older adults with appropriate provision of these services, tailored to the local health demographics. Examples include care home liaison services and community dementia teams supporting patients and their carers.
- All crisis teams will have older adult expertise in crisis care, either by bespoke teams or with dedicated older adult expertise in 'all-age' crisis support.

Other specialist teams

Eating disorder services

Children and young people's eating disorder services were one of the first areas to benefit from increased funding. Yet demand for these services has been significantly higher than anticipated (e.g. the total number of completed pathways in the first quarter of 2018/19 was up 4.2% for urgent cases and 12.9% for routine cases on the same period in 2017/18[53]), making the hoped-for saving on inpatient care as yet unrealised. A similar transformation is now needed for adult services, where geographical disparities, long waiting lists and limited consultant psychiatrist input are the norm.

New models of care are working to overcome a range of obstacles, but challenges remain around the integration of mental and physical health and across a range of transitions such as into independent living and between university and employment.

Vision

- ➤ By 2023/24, 95% of adults with an eating disorder who require urgent treatment should start this within one week and the same proportion with routine cases should be commencing treatment within four weeks.
- ➤ By 2028/29, there will be a dedicated community eating disorders service in every mental health trust, which is integrated with medical care and supports a seamless transition from children and young people's services to adult care and from inpatient care to reduce the length of stay.

Essential actions

- NHSE to introduce access and waiting time standards for adult eating disorder cases, in line with the benchmarks in place for children and young people.
- NHSE and CQC to review the existing quality and capability of adult eating disorder services to achieve parity with child and adolescent mental health services.

Personality disorder services

People living with personality disorders are often not served well by the current healthcare system. Some of the most effective treatment and support available includes talking therapies and, in particular, therapeutic communities, an intensive form of group therapy in which the experience of having a personality disorder is explored in depth.

As such, people with complex mental health problems who require psychotherapy provision often do not have their needs met through IAPT services.

Vision

➢ By 2023/24, people with complex mental health problems, including personality disorder, should have greater access to a range of evidence-based psychotherapies tailored to their needs.
➢ By 2023/24, the principles of reflective, psychologically minded practice and enabling environments underpin training of professionals and delivery of integrated models of care in community and inpatient settings across physical, mental health and social care.

Essential actions

• NHSE to develop a national commissioning strategy across NHSE (Tier 4 to 6) and CCGs (Tier 1 to 3) for services for people with a personality disorder to ensure that an appropriate pathway of care, with the provision of specialist services, is available in all geographical areas.
• NHSE, service users, carers, clinicians and voluntary sector organisations to co-produce a national quality framework and service specification for tier 4 personality disorder services and a robust method of evaluating the effectiveness of service delivery. In addition, tier 2, 3, 5 and 6 PD services should be subject to a national quality framework and robust methods of evaluating the effectiveness of service delivery, developed by CCQI.

Addiction services

People living with substance use disorders often have chaotic lives but can recover with an opportunity to build trust with health professionals. Yet, frequent changes of third sector providers have fractured the previous well-established working relationships and care pathways across the country. 'Payment by results' contracts have removed the incentive for services to take on patients with complex needs requiring longer, more intensive treatment. This constant changing of providers is damaging to vulnerable patients who cannot access the continuity of care they need, leading to them falling out of treatment and instead presenting at A&E or primary care. Alongside this, there has also been the removal of training opportunities to build expertise and resilience into the workforce.

In 2016-17, people aged 65 and over formed 30% of hospital admissions in England related primarily to alcohol.[54] This proportion has more than doubled since 2010-11 when this age group formed 14% of such admissions.[55] Over the same timeframe, the proportion of alcohol-related admissions in the 16−44 age group fell by 13 percentage points, from 43%[56] to 30%.[57]

Vision

➢ By 2028/29, every STP will have NHS specialist addictions services led by appropriately trained and experienced addiction psychiatrists. This should include adequate provision for children and young people and older adults experiencing addictions.

Essential actions

• DHSC and MHCLG should thoroughly review the commissioning of addiction services, including a review of potential service models, with consideration of reinstating the NHS as lead commissioners or mandating addiction services within local authority budgets.
• The Cabinet Office should continue the Life Chances Fund for outcomes-based interventions to tackle substance use disorders.

Veterans mental health services

The NHS has put in place special processes to encourage veterans to come forward to get treatment for their mental health problems – the Veterans' Mental Health Transition, Intervention and Liaison Service (TILS) or the NHS Veterans' Mental Health Complex Treatment Service (CTS). The aim of these services is to provide culturally acceptable mental health provision which will enable veterans to access treatments that have taken account of their needs, their language and their culture.

Vision

➢ By 2023/24, more veterans will be able to access NHS mental health services (TILS and CTS) with an initial face-to-face assessment within 2 weeks and a first clinical appointment, where appropriate, 2 weeks thereafter. There should also be a greater focus on increasing services available to female veterans.

Essential actions

- Should TILS and CTS prove successful (as measured by standard recovery/improvement metrics), NHSE should consider using this model as a blueprint for the development of other culturally-sensitive mental health services for important occupational groups who are known to be at risk of occupationally-related mental ill health. Examples include NHS staff, teachers and emergency services.
- DHSC to commission research into the effectiveness of IPS services for veterans in improving vocational rehabilitation outcomes.

Mental health crisis and acute services

Vision

EIP Services

➢ By 2023/24, 75% and by 2028/29, 85% of people experiencing a first episode of psychosis start treatment with a NICE-recommended package of care with a specialist EIP service within 2 weeks of referral.
➢ By 2028/29, 100% of specialist EIP provision is graded at level 4, in line with NICE recommendations.

Crisis Services

➢ By 2020/21, CRHTTs across England will have a 24/7 community-based mental health crisis response in all areas of the country and these teams will be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. These services then need to receive sustained investment after 2020/21.
➢ By 2023/24, these CRHTTs should incorporate a model specifically to meet the different needs and risks of older adults (particularly in relation to co-morbid physical health issues) and that these teams will be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.

Acute care

➢ By 2028/29, patients can expect to wait for a maximum of 4-hours for admission to an acute psychiatric ward or acceptance for home-based treatment following assessment, for those who need it.[58]
➢ By 2028/29, all patients are followed-up within 48 hours of discharge, rather than 7 days, as this reflects the evidence-base for preventing suicide post-discharge.
➢ By 2028/29, the availability of psychological therapies accessible in secondary, tertiary care and specialist settings to be substantially increased. For children and young people with more complex issues, they should access more specialised therapies if first and second line IAPT treatments have failed.
➢ By 2028/29, building on the current ambition to eliminate inappropriate external placements, trusts to eliminate inappropriate internal (within home provider) placements.
➢ Between 2019/20 and 2028/29, 85% bed occupancy in mental health trusts is consistently achieved.

Alternatives to admission

➢ By 2028/29, there are more places to receive support during a mental health crisis as an alternative to an admission to hospital. This should be extended to include children and young people and older adults and should not be limited to care homes in the case the latter.

Essential actions

• The government, DHSC and NHSE commit to act on the recommendations of the Independent Review of the Mental Health Act 1983 and provide local areas resourcing support as needed.
• Commissioners, providers and clinical networks in each area together undertake a service capacity assessment and improvement programme to ensure that they have an appropriate number of beds as well as sufficient resources in their CRHTTs to meet the need for rapid access to high-quality care.

Section 117 aftercare

The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care coordination, and patient and carer involvement focused on recovery. The care plan also outlines any risks, including details of what should happen in an emergency or crisis, and gives access to a care coordinator (usually a nurse, social worker or occupational therapist) to manage the care plan and review it at least once a year.

While the concept of CPA is good, in its current implementation it involves too much bureaucracy. There is an opportunity to bring the current requirements of the CPA, the Care Act, the Children Act, NHS Continuing Health Care (as well as other legal provisions) and section 117 care planning together in a coordinated way through a simple goal-orientated care and safety plan.

The entitlement to section 117 aftercare is limited to those who have been detained under specific sections of the Mental Health Act. It is not available to people who leave hospital after informal admission or detained under section 2. There are different responsibilities and rules on CCGs and Local Authorities.

A Safety Plan is an agreed set of activities, strategies, people and organisations to contact for support if someone becomes suicidal or if their suicidal thoughts get worse. They are also useful if someone is concerned that they might self-harm.

Vision

➢ Between 2019/20 and 2023/24, the average NHS trust score for 'continuity of care' in the CQC's community mental health survey[59] should improve year-on-year, with no trust posting a decline.

➢ By 2023/24, all patients in contact with mental health services have a simple goal-orientated care plan as well as a personalised safety plan including an agreed set of activities, strategies, people and organisations to contact for support if they become suicidal.

➢ By 2023/24, every person who is having suicidal thoughts or has started self-harming should have a Safety Plan. These plans need to include explicit reference to the removal of means of suicide or self-harm and need to set out actions which are proportionate, timely and clinically meaningful.

➢ By 2028/29, redesign what is meant by aftercare, including reforming eligibility criteria to improve equity of access, resolving some of the complex arrangements across health and social care, especially regarding funding.

Essential actions

• Building on the NCCMH's review of the CPA, NHSE to replace it with a shorter, meaningful plan for everyone in contact with mental health services, rather than those only recognised as needing additional support.

• The CQC to conduct an annual survey of experiences of people receiving care in inpatient mental health settings, as is already being done in physical health services. As part of this, the CQC should develop high-quality measures that feedback can be taken from carers of those people unable to directly comment on their experiences of the inpatient care.

Secure services and offender healthcare

Vision

➢ Between 2020/21 and 2028/29, the Liaison and Diversion services set up through the FYFVMH should continue to provide multi-agency assessment and referral service within police custody and the courts across England, but they should also hold cases on a short-term to prevent people falling through the net.

➢ Solitary confinement (defined as more than 22 hours in segregation without meaningful human contact) should be banned immediately for children and young people in the youth justice system.

➢ By 2023/24, the Community Sentence Treatment Requirement testbed sites pilot, currently being rolled out by the MOJ and DHSC, will be expanded to include better secondary care provision, to allow for those with more severe mental illnesses to benefit from community sentences.

➢ By 2028/29, 70% of adults receive dedicated mental health screening within 24−48 hours after entering the prison and 70% of people who need treatment or support are followed up within a month.

➢ By 2025/26, establish a minimum ratio of prison officers to prisoners (to provide basic safety of prisons, and protect from dangerous, mind-altering drugs and for prisoners to access mental health services in prison), and recommend an urgent assessment of how to better attract and retain a prison mental health workforce, including forensic psychiatrists, to deliver mental health care.

➢ By 2023/24, all young people identified as 'in need' by youth justice liaison and diversion workers have an appropriate service they can be referred to.

➢ By 2023/24, the integrated care project (also known as 'SECURE STAIRS') will be completely rolled-out and evaluation of the project will be published to that lessons can be learnt for future joined-up approaches.

Essential actions

- Commissioners to sustain investment in community forensic mental health services and roll out new co-commissioning funding and service models as set out in the FYFVMH.
- NHSE and NHSD to mandate Offender Healthcare services to collect and report patient-level mental health activity data every quarter.
- DHSC, MHCLG and the Ministry of Justice (MoJ) to fund a training strategy for health, social care and criminal justice professionals working with people with personality disorder.
- DHSC and MoJ to instruct the wider use of Mental Health Treatment Requirements with community sentences as an alternative to imprisonment in appropriate cases, at primary, secondary and tertiary health service provision, and early evaluation of proposed test bed sites.
- MoJ to trial Approved Premises as an alternative to remand prisons for those awaiting trial.
- MHCLG to review the availability of short-term accommodation for those released from prison with a mental health problem and report no later than 2019.
- DHSC and MoJ to develop a national strategy for assessing and treating ADHD in the criminal justice system given the strong evidence of links between ADHD and offending and reductions in reoffending with drug treatment.
- NHSE to review the commissioning of prison mental health services to ensure sustainable, high-quality services and the provision of access to old age specialist advice, given the ageing prison population.

This chapter has focused on the mental health of the working age and older adult population. The next chapter focuses on intellectual disabilities and autism and the service improvements that we would hope to see over the next 5 to 10 years.

8. Intellectual Disability and Autism

As a patient:
My mental health needs are recognised, and I know that I will receive timely support through high-quality care. I have the same opportunities as anyone else to live a satisfying, healthy, valued life and to be treated with the same dignity and respect and empowered to have a choice over my care.

As a clinician:
I am trained to be able to provide support for patients with intellectual disabilities or autism who have mental illnesses, or to refer them to linked services so that they can live fulfilling lives in community settings, wherever possible.

This chapter describes proposals for intellectual disability and autism services and the interface between mental health services.

The prevalence of mental illness within adults with intellectual disabilities is between 20.1% - 23.4% (excluding challenging behaviour and autism) compared to 16% of the adult general population.[60] Young people with intellectual disabilities and/or autism requiring adult services may be referred from a variety of services which may include primary care services, child and adolescent mental health services, paediatric services and neurology services. There is a wide variation across the country not only on how services are provided for this patient group but also up to what age it extends to. It is not uncommon to find that, although developmental difficulties have been identified by children and young people's services, no definite diagnosis of intellectual disability or autism has been made, which in turn can delay access to the appropriate adult service.

Autism and ADHD are hidden neurodevelopmental conditions long known to services for young people and those with an intellectual disability. However, they have come to the attention of adult mental health relatively recently with a growing recognition that, for disorders like autism, the majority are adult and do have an intellectual disability. 70% of people with Autism have a concomitant intellectual disability. Autism has a disparity across the various domains of cognition which means that someone of normal ability may appear to have a more generalised intellectual disability so that they are at risk of falling into a gap between mainstream mental health services and intellectual disability services.

The prevalence of ADHD in children with an intellectual disability is higher than that in the general population and it increases with increasing severity of the intellectual disability. The rates of 'hyperactivity' among young adults increase markedly with increasing levels of intellectual disability. The prevalence of ADHD declines with age in the general adult population. Recent research indicates the possibility of a longer and more persistent course of the disorder in those with an intellectual disability. This also seems to be the case with adults who have borderline or mild levels of intellectual disability compared to a more severe presentation.

There are six key barriers faced by people with intellectual disability and/or autism:

1) many mental health problems present differently in people with autism
2) some mental health therapies do not work in the same way that they do for others
3) general mental health services do not always accept people with intellectual disability or autism
4) the workforce is characterised by low numbers and insufficient training
5) diagnostic overshadowing continues to be an issue in that health professionals can attribute presentation and psychopathology to the underlying intellectual disability or ASD, rather than attributing it to a treatable mental illness, and
6) an undiagnosed ASD can also be attributed to the presence of an intellectual disability.

Vision

- By 2028/29, all STPs have:
  - specific mental health care pathways that cover the lifespan of people with an intellectual disability, autism or both.
  - GP-held registers for intellectual disability and autism.
- By 2028/29, there is a significantly reduced reliance on inpatient services for people with an intellectual disability.
- By 2028/29, the average life expectancy of people with an intellectual disability is extended.
- By 2028/29, community services for adults and children with an intellectual disability are significantly enhanced.

Essential actions

- NHSE, the Local Government Association (LGA) and the ADASS to review the implementation of the national service model for people with an intellectual disability and/or autism who display behaviour that challenges, including those with a mental health condition, and report no later than 2019.[61]
- NHSE should refresh the Transforming Care strategy in light of developing health and social care structures, which will come to an end in 2019, and seek to embed its ethos in current practice more widely.
- NHSE to fund innovations to ensure less reliance on inpatient services.
- HEE to support recruitment to all professions working with people with an intellectual disability and include education on people with an intellectual disability in all curricula.

This chapter has described proposals for intellectual disability and autism services and the interface between mental health services. The next chapter considers integrated and personalised mental health care for people with long-term conditions and older people with frailty.

9. Integrated and Personalised Care for People with Long-Term Conditions and Older People with Frailty, including Dementia

> **As a patient:**
> My wellbeing is a priority for all the services in my area. I get support for all my needs which is well linked up so that I receive coordinated and compassionate care and support and I never feel that I am caught between different services.
>
> **As a clinician:**
> I can work effectively with colleagues across different professions so that patients receive holistic treatment however complex their range of conditions and needs. I am proud that patients in my area receive high-quality care which myself and colleagues are continually seeking to improve.

The first part of this chapter sets out proposals for integrated and personalised care for people living with long-term conditions with a particular focus on diabetes services and support. The second part of the chapter includes proposals for improved dementia services.

Integrated and personalised mental health care for people with long-term conditions

Adults and older adults who have multi-morbidities are often not served well by the current healthcare system. This includes those living with substance use disorders, personality disorders, intellectual disabilities, neurodevelopmental disorders and those in contact with the criminal justice system.

Around 15 million people in England currently have at least one long-term condition and the population with multi-morbidities is increasing. In 2008, 1.9 million people had three or more long-term conditions, and this is expected to have risen to 2.9 million people by 2018.[62] Of these people with long-term conditions, 4.6 million have a co-morbid mental and physical health problem.[63]

NICE guidelines for those conditions (and other physical health problems) include little mention of the provision of psychosocial care and psychiatric input in particular. Instead, NICE tend to simply refer to separate guidance on depression in physical illness. Therefore, there is a risk that the need for adequate psychosocial care is overlooked by commissioners.

In recent years, there has also been a tendency to commission 'one-size fits all' IAPT services that cannot manage people with complex needs and, therefore, should be commissioned in conjunction with liaison mental health services.

Providing support to meet the mental health needs of carers (who are often older carers) is especially important for long-term conditions, as well as cancer and cardiovascular and respiratory diseases discussed in the next chapter.

Vision

➢ Between 2018/19 and 2020/21, integrated psychological therapy services for people with medically unexplained symptoms and long-term physical health conditions (LTCs) are rolled out across all CCGs. These services then need to receive sustained investment after 2020/21.

Essential actions

• NHSE to develop robust integrated pathways of care for long-term conditions that address psychosocial needs, including the management of co-morbid mental illness. Psychiatric expertise (particularly Old

Age psychiatrists) is required for the assessment and management of complex cases and should be built into the pathway.

- NICE to reconsider its current strategy, which separates physical and mental health recommendations in their guidance.
- All acute trusts to develop joint pathways with mental health trusts that incentivise integrated care through CQUINs. It is important that pathways are developed with input from specialist psychiatrists relevant for that group, such as pathways for child health and pathways for older adults. Consideration should also be given to third sector providers.

Diabetes and mental ill health

Mental health problems are common in people with diabetes and are associated with poor diabetes control, complications and increased mortality. They are disabling, poorly detected and inadequately treated.[64]

The prevalence of diabetes in people with depression or depressive symptoms is between 1.2 and 2.6 times higher compared to people without depression[65] and 2-3 times higher in people with schizophrenia, bipolar affective disorder or schizoaffective disorder.[66] [67] The incidence of diabetes ketoacidosis (a serious and potentially fatal condition) is more than a 10-fold greater in those with schizophrenia compared to the general population.[68]

This can be caused by an elevated risk of developing metabolic syndrome, possibly due to a combination of the following factors: diet, tobacco consumption, substance use, exercise, obesity, low degree of implementation of education programs and medication factors (i.e. psychiatric medications have a variable effect on glycaemic control, weight and lipids).[69]

Despite their high prevalence, mental health problems in people with diabetes mostly go undetected and untreated. One large study found that only half of the cases of depression were detected, of which less than a half received any treatment for depression.[70]

The emphasis on diabetes education as a solution for impaired adherence is giving way to a more psychological understanding of the person living with diabetes as a chronic disease. There is a growing awareness that diabetes services need to be provided by professionals who are skilled in providing psychological care. This involves working with the patient to manage any depression and supporting the individual to improve their self-care.[71]

Vision

- By 2023/24, everyone admitted with acute complications of diabetes whose aetiology is unclear or not medically explained is screened for mental illness and staff are appropriately trained to do this.
- By 2023/24, all patients prescribed second-generation antipsychotics are screened for diabetes.

Essential actions

- All mental health trusts to create a diabetes register, with immediate priority given to units where individuals may have prolonged inpatient admissions, such as secure hospitals.
- All mental health trusts to audit current practices in diabetes care and consider:
  - o the implementation of diabetes-related competencies as part of mandatory training with a particular focus on managing and avoiding hypoglycaemia and safe use of insulin
  - o basic skills for staff in the management of diabetes and mental health that are in keeping with their job role to care for patients with comorbidity
  - o awareness of local pathways and policies for contacting diabetes or mental health services, and
  - o if best practice tariff criteria are met for diabetes ketoacidosis and hypoglycaemia and for children and young people with diabetes.

Dementia care

It is estimated that 781,000 people in England have dementia.[72] As previously argued in Chapter 2, the likely long-term growth in dementia incidence and prevalence across England is substantial.

Dementia is recognised around the world as a public health priority[73] and can seriously impact a person's quality of life, through loss of their identity, their ability to function and their roles and relationships both in the family and in society.[74]

The focus of recent policy and service developments has been on improving the rates of diagnosis of dementia and as such, the national target for people living with dementia receiving a formal diagnosis has been consistently achieved since July 2016 and now exceeds the target of 66.7%.[75] However, concerns remain around the regional variability in access to a timely diagnosis, as well as the standard of post-diagnostic support available to people living with and those affected by dementia.

Vision

➢ By 2028/29, 90% of people with dementia should receive a timely diagnosis (increasing from 66.7% in 2018).
➢ By 2028/29, 90% of people with dementia are offered post-diagnostic treatment and support, which should be NICE-recommended, and the support needs should be outlined in the initial care plan. This care plan should be reviewed within at least 12 months of being agreed, then reviewed every 12 months in accordance with changes in the person's needs. Revisions should be jointly developed and agreed with the person (and, if applicable, their carer).
➢ By 2028/29, 90% of carers for people with dementia should also be offered post-diagnostic support and/ or a carer's needs assessment.

Essential actions

• CCGs and providers should adhere to the Dementia Care Pathway.[76]
• CCGs should assess the different levels of risk of developing dementia as well as specific needs, such as those with early-onset dementia, people from black, Asian and minority ethnic backgrounds and people with intellectual disabilities and capture this within their Joint Strategic Needs Assessment and local Dementia Needs Assessment.
• NHSE should consider new models to support older people with dementia and mental health issues in the community, moving beyond the model that depends on memory clinics. This might incorporate a model whereby patients remain under the care of an Old Age psychiatrist from diagnosis until death, rather than being discharged back to a GP. This should involve regular check-ups and brief interventions when problems are identified. This aims to improve the quality of care provided, reduce hospital admissions and GP caseloads.
• NHSE should consider the findings from the care home 'vanguard' pilots and review whether mental health input into care homes could be redesigned based on examples of good practice. A core part of this should include ensuring care home staff are supported to provide better care, using a quality improvement methodology.

The chapter has set out proposals for integrated and personalised care for people living with long-term conditions as well as proposals for improved dementia services. The next chapter describes mental health proposals for cardiovascular and respiratory diseases as well as cancer.

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10. Cardiovascular Disease, Respiratory Disease and Cancer

> **As a patient:**
> My psychological needs are addressed alongside care for physical conditions such as cancer or cardiovascular disease at all points of care, and my physical needs are taken seriously and acted on within mental health settings.
>
> **As a clinician:**
> I can support my patients' physical and mental health needs either through my own training or I can refer them to appropriate services which are readily accessible from the very start of their care and all throughout.

This chapter describes mental health proposals for cardiovascular and respiratory diseases as well as cancer.

Cardiovascular diseases and mental ill-health

The prevalence of cardiovascular disease in people with schizophrenia and bipolar disorder is approximately 2 to 3 times higher than those without these disorders and is more common in younger individuals.[77] For instance:

- the risk of coronary heart disease is 2-3.6 times higher in patients with schizophrenia and 2.1 times higher in people with bipolar disorder[78]
- the risk of developing a cerebrovascular accident (stroke) for patients with major affective disorder is 1.2 to 2.6 times higher[79] and 1.5 to 3.3-fold higher in patients with schizophrenia or bipolar affective disorder[80], and
- there is an increasing body of evidence that people with SMI are at an increased risk of venous thromboembolism (blood clots).[81]

The negative consequence of this is myocardial infarction (heart attack). People with major affective disorder are 1.7 to 4.5 times more likely to suffer a myocardial infarction and sudden cardiac death and patients with schizophrenia have been reported to be three times as likely to experience sudden cardiac death as individuals from the general population.[82]

Smoking is a key risk factor: about 42% of all cigarettes smoked by the English general population are smoked by someone with a mental health, drug or alcohol problem.[83]

Respiratory diseases and mental ill-health

The prevalence of chronic obstructive pulmonary diseases (COPD), such as chronic bronchitis and emphysema, is significantly higher among those with SMI than the general population.[84] There is also a higher incidence of tuberculosis among patients with schizophrenia compared with the general population.[85]

Furthermore, a nationwide, population-based study found schizophrenia to be associated with 1.37 times greater risk of acute respiratory failure and 1.34 times greater risk of mechanical ventilation.[86]

Vision

➢ By 2028/29, the commissioning of any new cardiovascular or respiratory disease service must specifically consider the psychological needs of that population from the outset and ensure that appropriately skilled mental health professionals are integrated and supported to function within that service.

Essential actions

- NHSE to develop robust integrated care pathways for patients with cardiovascular and respiratory diseases that meet their psychosocial needs, including the management of co-morbid mental illness.
- NICE to reconsider its strategy on separating physical and mental health recommendations in their guidance.

Cancer and mental ill-health

While there does not appear to be a higher incidence of cancer in people with mental illnesses compared to the general population[87], people with mental illnesses have worse survival rates after a cancer diagnosis. This suggests that problems arise during care rather than being due to late screening or diagnosis.[88]

The availability of psycho-oncology services for people affected by cancer is extremely variable across the country. However, many cancer services do provide some psychological care even if remains very limited and often provided by the third sector.

Vision

➢ By 2023/24, all patients on a cancer treatment pathway are referred to psychological and mental health support in the community, in a timely manner.

Essential actions

- NHSE and CCGs to ensure the commissioning of any new cancer service must specifically consider the psychological needs of that population from the outset and that appropriately skilled mental health professionals are integrated and supported to function within that service.
- NHSE to develop robust integrated care pathways for patients with cancer that meet their psychosocial needs, including the management of co-morbid mental illness.
- NHSE to recommend the widespread commissioning of integrated cancer psychological support services in acute trusts and cancer centres, consisting of a stepped care approach to managing psychological distress as per NICE guidance[89] (access to counselling, psychology and liaison psychiatry).
- NHSE to ensure that all GPs are able to refer patients on a cancer treatment pathway to psychological and mental health support in the community, in a timely manner.
- NHSE to commission services which should include primary care advice lines and prescriber support to GPs, led by psychiatrists with cancer care experience.
- NHSE to recommend commissioning of inpatient cancer liaison psychiatry services consisting of at least some dedicated medical and nursing resource, in line with demand.
- NHSE, HEE, National Institute for Health Research (NIHR), the Medical Research Council and the Wellcome Trust to liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences to significantly improve funding and support to integrated education and research involving cancer and mental health.

This chapter has described mental health proposals for cardiovascular and respiratory diseases as well as cancer. The next chapter discusses workforce, training and leadership.

11. Workforce, Training and Leadership: building a strong and resilient mental health workforce

> **As a patient:**
> 'My needs are supported by committed people who are appropriately trained, competent and experienced mental health professionals. I can build trusting relationships with staff, and the services I need are timely because the right staff are available to me.'
>
> **As a clinician:**
> 'I feel adequately supported to do my job to the best of my ability to help those with mental illnesses. I never have to work beyond what is safe because of staff shortages. I have been well trained and am able to work to a good standard while maintaining a healthy work−life balance. I am confident that there are clear training pathways available to me and am excited by the opportunities for development and the possibility of different roles in the future. I am proud to work in mental health services and, as more people join this profession, we can help a wider pool of people and make a significant contribution to the unmet need in mental health.'

None of the ambitions we have described in this paper are possible without the outstanding staff of the NHS, but they face unprecedented pressures from rising demand for health and care services. The workforce is now widely recognised as one of the biggest risks to delivery of the FYFVMH.

However, there are reasons to be optimistic. After a long-term decline in the numbers of psychiatrists working in the NHS, we are finally turning the corner with:

- a 2% increase in psychiatrists in the NHS in the past year, and[90]
- an increase of 33% in the number of doctors choosing to train in psychiatry after the first and re-advertised recruitment rounds compared to last year.[91]

This is welcome news and demonstrates what can be achieved with a concerted focus on recruitment and retention. We believe this reflects the efforts by the College and other stakeholders to improve the image of the specialism, ensuring positive information is shared (through careers fairs, online settings, etc.) and both students and trainees have positive experiences in structured settings (such as student and foundation training placements).

While we attract more doctors to choose psychiatry, NHS employers need to invest more than ever to make healthcare an attractive and rewarding place to work. This is crucial to sustain the increasing number of doctors opting for the specialty and to attract and retain a range of other professionals such as nurses, psychologists, occupational therapists, pharmacists, social workers as well as new roles.

We also need to maximise the staffing resource available to us and work in more flexible and novel ways. Psychiatrists are already working more flexibly with, for instance, consultant psychiatrists working across primary care settings, and liaison psychiatrists working at the interface between primary care, outpatients and hospital settings.

Vision

➢ By 2028/29, the supply of staff in mental health services will be secured to deliver the ambitious set of improvements set out in chapter five in this plan. An additional 70,348 staff will be working in mental health services (excluding the 8,000 expected to be working within Mental Health Support Teams). From these staff, 4,218 will be psychiatrists.
➢ By 2028/29, all mental health organisations will be mentally healthy workplaces and considered as model modern employers offering flexible, accessible and valuable careers to people from all communities.

- By 2028/29, mental health professions will be widely considered as rewarding careers with excellent employment prospects as well as unique opportunities to make a difference in people's lives.
- By 2028/29, the introduction of new roles will be found to be effective and successful in improving mental health service provision and helping to provide continuity of care for patients.
- By 2028/29, mental health professionals will be empowered to advocate for mental health across the wider health and social care system.

Of the additional consultant psychiatrists required, 37% comprise of posts from existing commitments in HEE's *Stepping Forward* plan, as well as a reduction in vacancy rates. Therefore, 63% of the required psychiatric workforce growth accounts for an expansion of services, meaning better access to quality care for people experiencing a mental illness. Further details are given below.

1. Health Education England's *Stepping Forward* plan is achieved in full
HEE has committed to an expansion of 570 additional consultant psychiatric posts by 2020/21. Since the implementation of this plan began[92], 31 consultant psychiatric posts have been filled. Therefore, at present, a further 539 posts need to be created.

2. The current vacancy rate is halved
By halving the overall consultant psychiatric vacancy rate[93] from 10% to 5% by 2028/29, this will mean an additional 240 posts are filled. Our proposal for an enhanced retention target, detailed later in this chapter, will also have significant implications for the rest of the mental health workforce.

3. Recruitment of 1,330 consultants to meet expanded access targets post−2021

Service	Additional consultant psychiatrists required between 2021/22 to 2028/29
Children and Young People's Mental Health Services (inc Eating Disorder Services)	363 [94] [95]
Perinatal Mental Health Services	10 [96]
Liaison Mental Health Services	220
EIP Services	40
Community Mental Health Services	500 [97]
Old Age Services	89 [98]
Forensic Services	47 [99]
Addiction Services	15 [100]
Intellectual Disability Services	39 [101]
Medical Psychotherapy Services	7 [102]
Total	**1,330**

If an alternative workforce trajectory is adopted, which enables more time for the necessary training infrastructure to be put in place for consultant psychiatry posts, the table on the next page provides some indications of the posts required to 2023/24. These numbers are predicated on the fulfilment of *Stepping Forward* and a front-loading of vacancy reduction, with 160 of the 240 aforementioned posts filled by 2023/24.

Service	Additional consultant psychiatrists in post between 2018/19 and 2023/24[103]
Children and Young People's Mental Health Services	193
Perinatal Mental Health Services	40
Crisis - CRHTTs	213
Liaison Mental Health Services	185
EIP Services	65
Community Mental Health Services	148
Old Age Services	45
Forensic Services	16
Addiction Services	4
Intellectual Disability Services	17
Medical Psychotherapy Services	2
Total	**929**

4. Recruitment of additional 569 SAS doctors, 645 specialty registrars and 889 trainees over the course of the decade to play an integral role in the achievement of expanded access targets.[104]

Essential actions

There are 22 short- and long-term actions the Government can take to ensure the mental health workforce is significantly expanded between now and 2028/29.

Implementing HEE's workforce plan, *Stepping Forward*, in full

In July 2017, HEE published its mental health workforce plan, *Stepping Forward to 2020/21: Mental Health Workforce Plan for Engla*nd.[105] The plan sets a high-level roadmap to create an additional 21,000 posts by 2020/21 to deliver the transformation set out in the FYFVMH.

Action 1: HEE, NHSE and DHSC should ensure *Stepping Forward* is implemented in full.

The plan includes key actions to increase workforce supply. The College is calling for those actions to be completed in order to fulfil the FYFVMH. This includes recruiting an additional 570 consultant psychiatrists and:

- developing an urgent action plan to attract and retain more clinicians to work in mental health services and psychiatry
- taking forward a number of international workforce initiatives including recruitment from overseas
- coordinating and funding a major Return to Practice campaign for psychiatrists and mental health nurses
- ensuring that psychiatry has a significant share of the Medical Training Initiative (MTI) allocation
- exploring changing medical school entry requirements so that psychology 'A' level is considered an accepted subject in order to increase the pool of medical student applicants likely to go on to become a psychiatrist
- developing solutions to release more time for consultants to provide skilled care for patients at most risk
- ensuring the priority of mental health is reflected in the UK Medical Licensing Assessment
- increasing the exposure to psychiatry during undergraduate and foundation training with the aim of having 100% of Foundation trainees having experiences in psychiatry

- reducing attrition rates from training programmes (including ensuring that all trainees get the agreed 1-hour direct supervision per week) and explore greater flexibility within the training, and
- securing access to workforce data from non-NHS sectors as soon as possible.

In this context, our estimates for 2023/24 and 2028/29 aim to fill gaps in line with the Government's ambition to achieve parity between physical and mental health.

Attracting students and doctors to choose psychiatry

The allocation of 1,500 new medical school places is welcome, although encouraging the new students to choose specialties facing a shortage, such as psychiatry, will be crucial. Our analysis of the 2017 Career Destinations report from the UK Foundation Programme Office indicated wide variation between medical schools in terms of numbers of Foundation Doctors moving onto psychiatry training.

The College will continue to work with HEE to run a campaign to encourage more medical students to #ChoosePsychiatry. We welcome the opportunity to work with HEE and medical schools to advise on the psychiatry module in the undergraduate curriculum and integrating mental health into the broader curriculum.

In addition, we believe that all medical schools will need to have plans in place to encourage more doctors to choose psychiatry. Our current research on the initiatives that impact medical students' likelihood to want to train as a psychiatrist should help inform those plans.

The Government also needs to ensure there are the adequate and appropriate foundation and specialty training posts to support the increased cohort of medical school graduates. This is supported by academic literature that shows that high-quality psychiatry placements and tasters in psychiatry increase the likelihood of trainees choosing psychiatry.[106] [107] The attitude and enthusiasm of trainers/psychiatrists leading and supporting placements are particularly important. It is crucial that teaching on mental health is delivered by specialists in the field rather than by general physicians. For instance, old age psychiatry needs to be taught by old age psychiatrists rather than geriatricians or general adult psychiatrists.

HEE has already increased the number of doctors in the Foundation Programme doing a 4-month psychiatry post to 45%. We call on the Government to commission a further expansion of high-quality and well-resourced placements in psychiatry.

Action 2: All medical schools to have plans in place to encourage more medical students to choose psychiatry.

Action 3: HEE to commission adequate and appropriate foundation and specialty training posts to support the increased cohort of medical school graduates and to ensure that:

- **at least 60% of doctors in the Foundation Programme do a high-quality four-month psychiatry post by 2023/24, and**
- **at least 75% of doctors in the Foundation Programme do a high-quality four-month psychiatry post by 2028/29.**

Attracting pupils to choose a career in mental health

Multidisciplinary teams are key to delivering person-centred care. Evidence supports multidisciplinary team working as the most effective means of delivering comprehensive services to people with mental health problems, especially those with long-term conditions. Multidisciplinary teams are also crucial if we want to improve care planning and safety, as described previously.

Based on the successes of the College's #ChoosePsychiatry recruitment campaign, we are calling on the Government to fund a campaign aiming at improving the recruitment of all mental health professionals involved in multidisciplinary teams. The objectives of this campaign would be to promote the benefits of a career in mental health amongst secondary school pupils, at a time when the choice of settings within which to work, the diversity of skills and the freedoms to innovate have never been greater.

Action 4: The Government to fund a collaborative 'Mental Health Careers' campaign aimed at secondary school students, and possibly teachers and parents.

Recruiting from overseas

In December 2017, 45% of all NHS psychiatrists and 50% of consultant psychiatrists had qualified abroad[108]. Recruiting from overseas will be crucial to achieving workforce objectives, and the College is clear that future workforce arrangements must include the facility for bringing doctors from overseas in the short term. The College supports the lifting of the UK visas and immigration cap on the numbers of doctors allowed to enter the UK on this scheme.

The Government should expand the list of shortage specialties to alleviate the shortfall in the workforce. This would allow the NHS to recruit in areas of particular shortage such as child and adolescent psychiatry.

Opening the MTI scheme up to more doctors and dentists would make a small but crucial difference to the current recruitment crisis by allowing MTI recruits to complete their training in posts that are being left unfilled by UK/EU/EEA trainees before returning home to benefit their own healthcare system. As stated in *Stepping Forward*, psychiatry needs to have a significant share of the MTI allocation to fill vacant training posts and free up the time of UK consultant psychiatrists who are having to fill the vacancies in training posts. In addition, the Tier 5 Visa for the MTI scheme needs to be extended from 24 to 48 months so that doctors can fully benefit from UK training before returning to their home countries.

Action 5: The Government to expand the list of shortage specialties (which currently includes old age psychiatry), to include specialties such as child and adolescent psychiatry (including child and adolescent consultant psychiatrists, higher trainees and SAS doctors in CAMHS).

Action 6: The Government to remove the cap on the number of doctors who can benefit from the MTI and extend the Tier 5 Visa from 24 to 48 months.

Supporting and retaining trainees

The quality of psychiatric training is key if we want to attract students to choose psychiatry.

Action 7: Deaneries and mental health trusts to put in place a range of measures as set out in the *Supported and Valued* report.[109] These include:

- **protection of the minimum of 1 hour of supervision per week with their psychiatric supervisor;**
- **a minimum of one teaching session per week provided through a local programme or on a recognised MRCPsych course, and**
- **timely allocation of psychotherapy cases with protected time for clinical sessions and supervision.**

There is clear existing and emerging evidence that younger generations of medical students and doctors expect their careers to develop in ways that are very different from the 'traditional' model of medical training. Greater flexibility, more part-time working, and stepping on and off the training ladder will be an increasing feature of the future workforce's working life.

The College believes that there should be further emphasis on lifelong learning, career development and management, particularly through credentialing. Posts need to be adaptable and able to change as post-holders get older and seek to pursue specific interests within job roles, including non-clinical roles (such as medical research and education) which are central to promote psychiatry.

Professional activities for consultants and specialty doctors must be protected to allow adequate time for continuing professional development (CPD), audit and quality improvement activity, appraisal, revalidation, supervision of trainees and management activity.

Action 8: HEE to work with RCPsych to develop and implement measures to make psychiatry training and careers in the NHS more flexible and attractive including expanding credentialing.

Action 9: HEE to restore the CPD budget to its 2013 level of £300m per year as opposed to the current £90m. A substantial proportion should be ring-fenced for mental health that is in line with the size of the mental health workforce, with an additional sum to reflect past disparity.

Academic training pathways are vitally important both for encouraging high-quality doctors into psychiatry (and other specialties) and for developing evidence-based quality care. In areas such as child and adolescent psychiatry and old age psychiatry, there are serious concerns around the capacity of clinicians to write grant applications or conduct clinical trials.

Action 10: HEE to increase the number of trust-supported academic activities and safeguard academic sessions, as an important tool for recruitment and retention.

Supporting and retaining staff

The College believes there should be an increased focus on existing staff wellbeing. The College has a range of initiatives to support psychiatrists including the 'StartΨell' guidance for new consultants and the Psychiatrists' Support Service, which is a free, confidential peer support and advice service for psychiatrists at all stages of their career who find themselves in difficulty or in need of support.[110]

The NHS Staff Survey 2017 reported that 38.4% of the workforce had felt unwell due to work-related stress and one in two (52.9%) staff had attended work despite feeling unwell because they felt under pressure from their manager, colleagues or themselves to do so[111]. Stress, distress, burnout, self-harm and the loss of life due to these stressors are unacceptable and should be urgently addressed.

Employers of healthcare staff must recognise and act on their responsibilities in this area. Staff wellbeing and mental health continue to have a strong impact on patient health outcomes, productivity and financial costs in the NHS and should be an integral part of quality improvement initiatives, recruitment and retention campaigns.

Action 11: Mental health employers to implement the mental health core and enhanced standards as recommended in Thriving at Work: the Stevenson/Farmer Review of Mental Health and Employers.[112]

Action 12: HEE, NHSE, DHSC and other relevant organisations should implement the recommendations made by the Commission on the Wellbeing and Mental health for Staff and Learners in the NHS (led by Sir Keith Pearson), due to be published by 31st December 2018.

Action 13: The CQC to embed wellbeing measures as part of its methodology.

The College welcomes NHSI's programme to improve staff retention in trusts, and in particular the targeted support for mental health trusts. Thanks to this programme, trusts across England should be better equipped to improve staff retention by 2021.

By 2028/29, NHSI should work with mental health trusts, and community and acute trusts where they are providing mental health services, to support them to meet an annual 4% improvement target in retention rates. This would seek to incentivise trusts to address the contributing factors impacting on staff wellbeing, including excessive workload; long hours; high responsibility with perceived lack of control; poor work−life balance; pressures on CPD; fear of investigations and litigation; and lack of support from both management and peers. All mental health professionals involved in multi-disciplinary teams should be given comprehensive and adequate job plans that provide them with sufficient time to undertake the tasks required to a safe and high standard as well as professional development activities. Supporting professional activities (SPAs) should be protected in consultant psychiatrists and SAS doctors' job plans.

Action 14: NHSI to set a yearly 4% improvement target in retention rates to be met by:

- **50% of mental health trusts, and community and acute trusts where they are providing mental health services by 2023/24.**
- **100% of mental health trusts and community and acute trusts where they are providing mental health services by 2028/29.**

Other initiatives could be further explored. For instance, HEE could test a graded scheme to offer senior mental health professionals paid sabbaticals based on length of service (e.g. up to 6 months after 10 years, up to 1 year after 15 years). This would allow senior professionals to work in an area relevant to their subject, to remain motivated to stay in the profession and bring back new expertise and ideas to their role.

Action 15: HEE to fund a pilot programme to test paid sabbaticals for senior mental health professionals.

Encouraging highly-skilled staff to return to practice in the NHS

There is evidence that consultants are retiring early or reducing their hours in light of the recent changes in thresholds for tax liability for pension funds accrual. These changes also have an impact on consultant psychiatrists applying for awards for additional non-clinical work which is vital to delivering good patient care (e.g. work for national organisations such as NICE, NIHR and RCPsych, as well as teaching, managerial and academic activities). Such awards may make the consultant liable to the pensions tax, and therefore act as a disincentive for doing additional, valuable work.

These new tax penalties are punitive and act as a major disincentive to older consultants staying in their roles for longer and taking up both clinical and relevant non-clinical duties.

Action 16: The Government to urgently review tax penalties to prevent the loss of highly-skilled and experienced senior mental health professionals.

Revalidation provides assurance to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practice. However, retired psychiatrists have to overcome additional challenges when they go through the revalidation process, such as the difficulties to meet current targets if they want to do a small amount of work. Moreover, the cost of revalidation can discourage some people to continue to work or return to practice.

Action 17: The GMC to urgently review revalidation rules and process post-retirement to address the challenges faced by retired psychiatrists.

It is equally important to review psychiatrists' job plans as they become more senior to ensure their expertise is used in the most effective way to encourage them to continue to work in the NHS and/or to provide attractive job plans for retired psychiatrists.

Action 18: Employers to review psychiatrists' job plans to ensure they are adequate for retired psychiatrists who want to return to practice.

Recruiting and retaining Physician Associates in mental health

The College welcomes the development of new roles within the mental health sector, including the Physician Associate (PA) role, and supports this professional group being externally regulated. The College is keen to ensure that PA training has a strong foundation in mental health and recognises the benefits PAs bring to mental health, including support with the physical health care of mental health patients. This should not, however, undermine the continuing need for sub-speciality input in such areas as children's and older people's care.

In June 2017, 2.1% of the PAs who responded to the FPA Census 2017 confirmed they were working in psychiatry. This means that, according to the census, 4 PAs (of the 182 respondents) were practising in psychiatry.[113] The introduction of additional PAs in the mental health system can further enable consultants, specialty doctors and trainees to work to the top of their skill-set to improve productivity. We welcome the commitment to expand PAs in training to over 1,000 per annum.[114] The College strongly believes that at least 10% of those new PAs need to work in mental health.

Action 19: The Government to call for at least 10% of the 1,000 PAs being trained each year to work in mental health (including liaison services and GP practices) from the 2019/21 intake onwards.

Over the coming months, the RCPsych will chair a task and finish group set up by HEE to consider how this expansion could be delivered. The group should be working on various issues, including the supervision requirements of PAs and the impact on the consultant workforce, mental health teaching in the formal PA curriculum, and revalidation requirements.

An important part of the work will be to develop a clear career pathway to make PA training and careers in mental health simultaneously flexible, attractive and rewarding. This will be crucial to sustaining the new role.

Action 20: The Government to accept and implement the recommendations made by HEE's task and finish group on PAs.

Promoting mental health leadership

Realising the significant benefits of integrating mental and physical health requires the empowerment and support of local leaders to advocate for mental health across the wider health and social care system. As we move to integrated systems of care, improving the voice and capability of mental health leadership will enable us to build on the progress achieved through the FYFVMH.

Action 21: RCPsych to work with its members to grow mental health leaders of the future, with a particular focus on gender and ethnic diversity of leadership.

Action 22: HEE to establish a Future Mental Health Leaders programme led by the NHS Leadership Academy, in partnership with professional bodies such as RCPsych, building on the similar 'Future Clinical Commissioning Leaders' programme. They should promote leadership courses to middle managers who are underrepresented in the Leadership Academy.

12. Clinical Review of Standards

> **As a patient:**
> I receive high-quality care in a safe, clean, caring environment and I know that if I raise a complaint or a concern about a service this will be taken seriously and acted on and that services will learn from any mistakes.
>
> **As a clinician:**
> Where I work is clean and safe and has a positive atmosphere. I am well supported to work with my colleagues to continually improve the quality and safety of the care provided to patients. Services are inspected proportionately, and the information gained is used to improve services and outcomes for patients.

This chapter considers proposals for safe and effective mental health services, including quality improvement.

Safe services

The NHS is on a journey to becoming one of the safest, most effective and transparent health systems in the world. Building on the success of the former Secretary of State's Safety Improvement Programme with the Care Quality Commission (CQC) and NHSI, the Government should aim to make mental health services the safest in the world.

Through the CQC's inspections, there are currently many examples of good and outstanding care in mental health settings – but also too much poor care, and variation in quality and access across different services. Some types of service perform particularly well, especially community mental health services for people with an intellectual disability or autism (80% rated as good and 9% as outstanding) and community-based mental health services for older people (76% rated as good and 10% as outstanding). In these services, the CQC found that staff were skilled and appropriately trained, patients and carers were involved in planning their care, and there were systems in place to deal with urgent referrals.[115]

Yet of the 54 mental health trusts rated by the CQC as of September 2018, only 27.8% are rated as good on safety (none as outstanding), which is marginally better than the acute sector at 26.5%.[116] The biggest concerns relate to the poor physical environment, restrictive interventions, sexual safety, safe medicines management and low staffing levels.

The leadership provided in mental health trusts impacts upon the frequency and length of out-of-area placements, the quality of care provided, increased frequency of suicide, and longer inpatient stays. Currently, 75.9% of mental health trusts are rated as good or outstanding for being well-led and 3.7% are rated as inadequate. This compares to the acute sector where 62.6% are good or outstanding and 5.4% are rated as inadequate.[117] Building on this foundation, mental health trusts should lead the way in improving the safety of services.

Vision

If the NHS is supported to build capacity in the system through a commitment to increase the workforce and increase capital funding:

➢ 43% of mental health trusts will be rated as good or outstanding on safety by 2023/24 and 60% by 2028/29 – an improvement from 27.8% in September 2018.
➢ 81% of mental health trusts will be rated as good or outstanding for being well-led and 90% by 2028/29, with none rated as inadequate by 2023/24 – an improvement from 75.9% and 3.7% respectively in September 2018.

Essential actions

- DHSC and NHSE to fairly apportion additional capital funding to mental health trusts based on STP estates and capital plans.
- NHSE to fairly apportion future revenue growth to ensure mental health trusts are able to meet and surpass national access and outcome targets, reduce inappropriate out-of-area placements and train staff to deliver a world class service.
- The CQC and NHSI to significantly increase and enhance the quality improvement support available to mental health trusts to enhance their safety and quality.
- The CQC and NHSI to continue to work together to provide a bespoke improvement and support offer to all trusts.
- NHSI to fairly apportion future Provider Sustainability Funding to mental health trusts.
- The CQC to continue to implement its current strategy, which should be reviewed and extended in 2021, to:
    - move to a more responsive inspection model which is proportionate, and risk-based so that areas which require improvement or inadequate receive more attention, reflected through the frequency of inspections;
    - use the information they have about a service to focus inspections on specific services – such as maternity care – rather than the whole provider; and
    - build an in-depth and shared understanding of the local context and the quality of services, particularly across developing care structures, with inspectors, providers, commissioners and partners.

Effective services

Currently, 66.7% of mental health trusts are rated as good or outstanding in their effectiveness, compared to 63.9% of acute trusts and 80.0% of community trusts.[118] NHSI recognise there is wide variation in care hours per patient day between mental health services (from 5−30 hours per patient for adult mental health with an average of just under 8). To increase the quality of care by increasing the hour's professionals can spend with their patients, there must be a reduction in red tape and bureaucracy.

There is also variation in the quality of care received. In the community, 65% of respondents report a positive experience of overall care (a score of 7 or more out of 10). The CQC report marked differences in the experience of care between people of different age groups, religion, sexual orientation, CPA status, diagnosis and length of contact.[119] Over the next 10 years, we need to raise standards in mental health care, working with commissioners and providers.

Quality improvement

The Getting It Right First Time (GIRFT) programme aims to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes. In mental health, the GIRFT programme is currently looking at adult acute and urgent and emergency care, children and young people's acute and emergency care, and adult rehabilitation and complex care.

The College Centre for Quality Improvement also works with mental health services to improve the standard of care that people with mental health needs receive. They work with more than 90% of mental health service providers in the UK. One of their main activities is developing service standards and reviewing services against them to help them improve the quality of care they offer. They also accredit services that can demonstrate high levels of compliance with our standards.

They currently run 22 of these projects working with various types of mental health services and over 1,500 services participate. Membership of some of these projects (e.g. forensic, inpatient CAMHS and perinatal) is a requirement of NHSE's commissioning contracts.

The acute care collaboration vanguard in the West Midlands, MERIT, is an example of hospitals linking together to improve their clinical and financial viability, reducing variation in care and improving efficiency, and should be rolled out to other mental health trusts.

Vision

➢ By 2023/24, 72% of mental health trusts are rated as good or outstanding for effectiveness, with this percentage rising to 80% by 2028/29.
➢ By 2023/24, more people using mental health services in the community, inpatient settings and IAPT services have a positive experience of care and the underlying reasons for differences in access (including access to evidence-based NICE-concordant treatments) and experiences between different groups are identified and addressed.

Essential actions

- Building on the early success of the GIRFT programme, NHSI should expand the programme to cover other mental health services, such as community services for adults and older adults; personality disorders; as well as intellectual disability services, for example. The proposed new regional structure across NHSE and NHSI will need to be implemented at pace to help providers achieve this.
- NHSE and NHSI should mandate all mental health services to participate in a quality improvement network to help them monitor and improve the quality of the care that they offer.
- Building on the learning from the acute care collaboration model in the West Midlands, NHSE and NHSI should support the roll-out to other mental health trusts, where appropriate.
- NHSI should implement Lord Carter's recommendation to expand and extend benchmarking data for mental health services on the Model Hospital, so trusts can identify efficiency and productivity opportunities.
- As recommended by Lord Carter, NHSE should help strengthen commissioning and contracting mechanisms for mental health services by supporting providers and commissioners to work together within STPs/ICSs to develop model frameworks for specifications of services.

This chapter has presented proposals for safe and effective mental health services, including quality improvement. The next chapter considers digital and technology proposals for improved mental health care.

13. Digital and Technology

> **As a patient:**
> Where I am happy for my information to be shared, the range of people who support me can access relevant data so that the best care for me can be provided quickly without me having to repeat myself and I have more time with clinical staff.
>
> **As a clinician:**
> My time with patients is maximised by better use of technology and electronic patient records. New technology is incorporated into my training and always readily accessible when I am working - saving me time and allowing me to deliver better care and maximise my skills.

This chapter presents proposals on the use of technology and digital solutions as well as modern electronic patient records.

Better use of technology and digital solutions

The use of smartphones and tablet devices by the public has proliferated in all ages, social classes and ethnic groups. Patients are already using them to access a broad range of services which are increasingly adopting digital approaches in support of more effective and efficient care. Some examples for expansion are given below.

Global Digital Exemplars
The Global Digital Exemplars in mental health are internationally-recognised NHS providers delivering exceptional care efficiently, using world-class digital technology and information. In some cases, this will be sharing software or a common IT team. Others will adopt standard methodologies and processes. Digital technology can also accelerate more sophisticated and acceptable service delivery models in mental health.

Test Beds
RAIDPlus integrated mental health urgent care test bed covers the 1.3 million population of Birmingham and Solihull, where approximately 25,000 people access mental health urgent care services each year. The innovative project includes a mental health urgent care coordination centre with mobile crisis workers and teletriage workers providing prevention support before a crisis arises. Predictive technology helps staff know when people are likely to enter a crisis. There are also digital tools such as online support, electronic early warning signs and crisis intervention plans and risk assessments that patients and other care professionals can use.

Internet of Things
A project led by Surrey & Borders NHS Foundation Trust supports around 700 people with dementia and their carers through the use of technology to enable them to live in their own homes for longer. Individuals and their carers will be provided with sensors, wearables, monitors and other devices, which will combine into an 'Internet of Things' to monitor their health at home. The information from these devices will help people take more control over their own health and wellbeing, with the insights and alerts enabling health and social care staff to deliver more responsive and effective services.

The project aims to prevent or delay the need for costly long-term care in nursing homes and reduce the need for unplanned hospital admissions or GP visits, thereby taking the pressure off other NHS services.

Telepsychiatry
The growing digital literacy among patients and digital capability in services should be exploited to allow the routine use of telepsychiatry – an exciting new way for patients to engage with services and speak to

clinicians. Telepsychiatry can involve the use of internet video platforms as a tool to undertake psychiatric interviews or follow-up interviews; audio consultations over the internet; or telephone consultations.

The increased use of telepsychiatry will help patients deal with geographical distances (e.g. in students living away from home), mobility difficulties (e.g. patients who are unable to drive due to medication or physical disabilities) or practical concerns (e.g. carers unable to leave someone unattended). It would also help to reduce costs, and research suggests there is wide acceptability of video consultations by patients of all ages.

However, telepsychiatry should be an adjunct to, rather than a substitution for, face-to-face consultation and patients should always have the choice of a face-to-face consultation. People with dementia, people who lack digital literacy or find technology challenging, people who have cognitive impairment, people with an intellectual disability and people who do not have access to digital platforms must not be disadvantaged.

Avatars

Novel technological solutions can enhance the care and treatment currently offered to patients. Avatars are digital self-representations which can be used to facilitate online communication between clients and therapists, and among peers, and may in future deliver psychological therapies. Avatars appear to serve many functions including facilitating the development of a virtual therapeutic alliance; reducing communication barriers; promoting treatment-seeking through anonymity; promoting expression and exploration of client identity; and enabling therapists to control and manipulate treatment stimuli. Further research into the feasibility and ethical implementation of avatar-based psychotherapies is required.[120]

Babylon and similar

Initiatives such as Babylon can allow people to access free chat services to check their symptoms quickly or get instant advice on what to do if they are feeling unwell. They can make mental health support more accessible and affordable for people with mild mental health problems.

Babylon also offers 24/7 access to GMC-registered GPs as well as affordable, confidential access to therapists to get support for several issues, including low mood, depression, anxiety, stress, phobias, eating disorders, and others. Some people appreciate the ability to access support from their own home, and/or to be able to track their sleep and stress levels by inputting data in a dashboard.

Vision

➢ By 2023/24, there is a step-change in the use of technology in mental health settings, building on the learning from the Global Digital Exemplars, Test Beds and the Internet of Things.
➢ By 2028/29, telepsychiatry is used routinely across all mental health settings, where appropriate.
➢ By 2028/29, the care pathway under the Mental Health Act is digitised to adopt a standardised approach and support enhanced system-wide information flow, developed through co-production.

Essential actions

• DHSC and NHSE to invest in testing new technologies to investigate which are most practical and effective in the NHS.
• DHSC and NHSE to provide greater investment in digital infrastructure to ensure innovative technology functions smoothly.
• HEE to invest in training to raise the digital literacy of the NHS workforce.

Modern electronic patient records

Mental health services have been at the forefront of the use of electronic patient record (EPR) systems for many years. However, the potential benefits of modern software, apps and clinical informatics are not being realised as commercially available EPRs are technically outdated and not fit for purpose. Mental health care is uniquely dependent on a detailed patient narrative but currently available EPRs make recording overly time-consuming, and patients' stories and important clinical information are often unrecognisably fragmented across multiple fields.

Overall, clinical information systems are not adequately usable for clinicians resulting in considerable time in entering information while limiting their ability to extract the relevant information they need to monitor and manage the quality of care. Clinical interpretation of data not only has benefits for patients and the wider population but also enables clinicians to benchmark themselves against their peers which helps to drive up quality.

Clinical administrative work has become a huge burden and focus for all mental health staff significantly and negatively impacting on clinical quality, safety and productivity. This has been recognised by the CQC and Lord Carter's recent review into mental health productivity, which shows that community clinicians are spending over 33% of their time on documentation and reporting; more than face-to-face patient care.[121] The potential for modern software to support reliable care pathway management, evidence-based interventions, outcome measurement and clinical interpretation of data to benefit patients and populations is not being realised. Despite mental health services being at the forefront of shared decision-making, patient access to their clinical record and the ability to contribute to their care and care planning is limited by outdated systems. The Digital Maturity Assessment does not take in to account the adequacy of clinical software used and the impact on productivity and the quality of patient care.

Vision

➢ By 2028/29, IT systems are interoperable between all health providers, primary and secondary care, and between themselves and providers of social care.
➢ By 2028/29, EPR systems provide a modern solution that supports high quality, safe and cost-effective mental health care that meets the needs of the end-user. They support efficient input of clinical data, pathway management, evidence-based care and outcome measurement, and have an open application programming interface (API) to enable clinicians to develop and connect innovative software solutions to improve patient care and outcomes.

Essential actions

• DHSC to allocate capital funding for improvement in IT hardware and software in mental health trusts.
• NHSD to work with primary care practices so that all Summary Care Records include vital mental health information, where individuals consent for their information to be shared.
• Trusts to provide core administrative support for consultants to improve clinical productivity.

This chapter has presented proposals for the use of technology and digital solutions in the NHS as well as modern electronic patient records. The next chapter considers research and innovation.

14. Research and Innovation

> **As a patient:**
> I am able to benefit from a range of the most up-to-date care and treatment which meets my individual needs. Other patients like me play a big part in research and innovation, and I can see our diverse experiences reflected in decisions and outcomes.
>
> **As a clinician:**
> I am proud to be able to provide my patients with cutting-edge care and treatment tailored to best meet their needs due to increased research into mental illness and treatments. Services and treatments continue to develop and improve due readily available datasets and the research of clinical academic psychiatrists working with research agencies.

This chapter describes proposals for world-leading mental health research and academic psychiatry.

World-leading mental health research

Since the publication of the Mental Health Research Framework in December 2017, the former Secretary of State laid down a "Grand Challenge" to come up with a 20-year vision for mental health research, building on the ambitions of the ROAMER project.[122]

This is welcome, and we trust that momentum will be maintained under the new Secretary of State, because mental health currently receives less than 6% of UK health research funding.[123] Within this, we know that spending on research for children and young people and intellectual disabilities is particularly constrained. There are also concerns that the lack of clinical drug testing involving older people results in excessive prescribing of off-licence medication to that patient group.

To ensure research influences policy and clinical practice at the earliest opportunity, the Government should enable easier access to existing datasets for researchers. For example, there was a long delay in transferring the latest Adult Psychiatric Morbidity Survey (APMS) data to the UK data archive, and there is a risk-averse process in place for allowing researchers to access it. This means researchers devote much of their funding to accessing the data rather than on actual research, and this is an issue in terms of parity. Moreover, it is time for parity in research opportunities for all trusts, to enable the NHS to be a leading research sponsor.

Clinical academic psychiatrists are essential for leading research and development within clinical services, however, between 2007 and 2017, there has been a 21.7% decline in their number.[124] Without addressing this situation, improvements in healthcare will stagnate, there will be no innovations and our patients will not have access to the best care possible. As leading educators, clinical academic psychiatrists are central to the development and delivery of the curricula of medical schools and also during clinical training to develop the next generation of doctors.

Vision

➢ By 2028/29, there is fair and equitable funding of mental health research drawing on the ROAMER priorities.

➢ By 2028/29, the decline in academic psychiatry posts will have been reversed with a 50% increase in Clinical Senior Lecturer posts

➢ By 2028/29, every medical school will have an academic department of psychiatry with psychiatry being taught effectively to all medical students.

Essential actions

- DHSC to commission regular prevalence surveys for adults (with the next report no later than 2023) and for children and young people (with a report, following the one due in 2018, no later than 2023).
- DHSC to fund a follow-up survey to track the outcomes of the care received by the children and young people in the prevalence survey who have given informed consent. This will allow researchers to align findings and track data against better-developed indicators to help the Government better plan for the next ten years. It would also provide necessary information about what happens to children and young people over time.
- DHSC to ensure that eating disorders are recognised within both prevalence surveys, after being excluded from the most recent iteration of the APMS.
- Government to host a Mental Health Research Summit in 2019 that draws on the Grand Challenge and ROAMER programmes.
- NHSE, HEE, NIHR, the Medical Research Council and the Wellcome Trust to liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences and other relevant stakeholders to provide required funding and support to develop careers of academic psychiatrists.
- HEE to address significant barriers in clinical academic career pathways in mental health research, and to provide greater support for post-doctoral research fellowships, the transition to academic clinical lecturer and establishment at senior lecturer level.
- The Medicines and Healthcare products Regulatory Agency (MHRA) to improve drug testing methodologies to include older people with co-morbidities. This might, for example, include ways of getting over issues of capacity by encouraging people to make future wishes statement on this issue whilst they still have the capacity.
- DHSC and HEE to ensure that research into functional psychiatric illnesses should include older adults as a discrete group.

This chapter has described proposals for world-leading mental health research and academic psychiatry. The next chapter discusses the system architecture needed to deliver many of the proposals set out in this paper.

15. System Architecture

As a patient:
'My mental wellbeing is a priority for all the services in my area. I get support which is well linked up giving me a coordinated and compassionate response so that I never feel that I am caught between different services.'

As a clinician:
'Leaders in my area prioritise our work to help those with mental illness and I can work effectively with colleagues across different professions so that patients receive holistic treatment. I am proud that patients in my area receive care that is as good as, or better than in other areas of the country.'

This chapter sets out proposals for the formation of integrated care systems and providers; payment, outcomes and other system levers; data and transparency; and governance and accountability.

Integrated Care Systems and Providers: empowering mental health leaders to develop the healthcare services of the future

Realising the significant benefits of integrating mental and physical health requires the empowerment and support of local leaders to advocate for mental health across the wider health and social care system. As we move to integrated systems of care, improving the voice and capability of mental health leadership will enable us to build on the progress achieved through the FYFVMH. Local mental health leadership must also include people using services.

The formation of STPs, ICSs and ICPs is an important opportunity to realise the potential of integrating mental health within primary, acute, urgent and emergency care, public health, social care and prevention as well as with police forces and prisons. In many STPs or ICSs, it is already possible to see the impact, with local systems rising to the challenge and recognising the opportunity of investing in mental health to deliver a more sustainable health and social care system. However, there is still significant variation in the desire, ability, resources and structures to achieve this.

STPs and ICSs have no legal basis, and so depend on the willingness of local leaders to participate. These relationships are fragile. When planning healthcare services on an STP footprint – or any similar footprint of the future – senior mental health leadership must be at the heart of local decision-making structures. Currently, only two of the 44 STP Leads are from mental health trusts; most are from CCGs or acute trusts.

As 14 areas work towards fully integrating their services and funding as ICSs, it is essential that commissioning, design and implementation of these models of care are consistent with the requirement to deliver parity of esteem, with mental health integral from the initial design stages. With an ambitious target of scaling these models to cover half of the country by 2021, there is a great onus on local health systems to be innovative and employ contractual changes that are likely to span 5−10 years.

Mental health services are at a critical point in their evolution and under exceptional operational, workforce and financial challenges. The College is clear about the need to address these by (i) expediting the integration of care, (ii) delivering the objectives of the FYFVMH, (iii) affect the productivity gains outlined in the recent report from Lord Carter and solutions to workforce shortages, and (iv) maintain the progress made on the CQC's ratings and financial performance.

We are also clear that STP/ICS's short- and medium-term strategies should be to strengthen mental health leadership at a senior level rather than on organisational mergers which have been demonstrated to destabilise leadership teams and operational and financial delivery, and to cause significant patient, public and political disquiet. Effective care integrated and delivered at a patient level does not need to be dependent

on the organisational form if underwritten by senior leaders across organisations. This is not to dismiss the potential benefits of organisational mergers in providing cost-effective integrated care, but there should always be a full risk/benefit analysis of the timing of any merger so as not to unduly disadvantage mental health services and the people who use them at such a critical time.

The opportunities of integrating mental health services systematically into the wider health and social care system through STPs/ICSs are considerable but this can only be achieved by ensuring mental health leaders are at the very heart of decision-making.

Vision

➢ By 2019/20, every ICS will have mental health reflected as a top priority with the full programme delivery supported and tracked at ICS board level.
➢ By 2019/20, every ICS will have a mental health investment strategy, signed off by the ICS board and in place across partners in the ICS, including:
    o   plans for the use of additional mental health funding in baselines for each mental health deliverable and meaningful delivery of the Mental Health Investment Standard;
    o   quality assurance of mental health delivery, including evaluating the value and return on investment of mental health programmes to facilitate forward planning; and,
    o   agreement across the health system that efficiencies delivered through mental health initiatives will be reinvested back into mental health services to promote sustainability.
➢ By 2019/20, every ICS will have a credible workforce plan to demonstrate how it will be meeting the mental health priorities of the local population.
➢ By 2023/24, senior mental health leadership will be a core component of all place-based planning, including STPs, ICSs, ICPs and any other new model of care.
➢ By 2023/24, there is greater leadership from managers, particularly middle managers, to tackle the culture of bullying and harassment in the NHS.

Essential actions

•   NHSE should only approve the formation of an ICS/ICP if local system leaders have described a clear plan and commitment to achieve access and waiting time standards for mental health and the mental health workforce plan, and CCGs are meeting or exceeding the Mental Health Investment Standard. This should be part of a more sophisticated approach to assessing the performance of STPs and their readiness to progress to an ICS or ICP as directed by a joint national transformation strategy.
•   In recognition of the significant benefits of, and need to expedite, integration of mental health and physical health services, STP/ICS leaders should ensure at least one senior mental health leader in the programme management team is responsible for overseeing the implementation for each new model of care and involved in contract negotiations for ICPs. STP/ICS leaders should also engage or at least have input from specialists where the service encompasses a special group such as older people, children and young people, or those requiring specialised health services.
•   Mental health leadership at an STP/ICS level must always include people who use services.
•   NHSE and NHSI should review all organisational mergers which include mental health services in the short- to medium-term given the lack of evidence of the associated impact, and in the long-term must require a comprehensive risk/benefit analysis.
•   NHSE and NHSI should rate each STP/ICS on their mental health plans, level of planned integration, and leadership representation (including people who use services) and support those that need further development. STPs/ICSs exceeding these core expectations should work with those who are struggling through a peer-learning approach.
•   NHSE and NHSI should systematically capture and share learning from areas that are furthest ahead, including their governance arrangements and service models, to accelerate progress in other areas and to provide clarity about what is permissible within the current legal framework.

- NHSE should assess the benefits and any unintended consequences of these structures compared with improving joint working through ICSs, including the scope of the draft Integrated Care Providers contract, particularly whether mental health services should be incorporated, either in a partially-integrated or fully-integrated capacity.

Payment, outcomes and other system levers

The FYFVMH called to end the use of unaccountable block contracts. Care clusters, mandated since 2012, aim to describe a group of people with similar mental health needs and are being used by many providers as the basis for payment. They have been criticised for not easily mapping to diagnoses, missing the complexity of some populations and failing to incentivise outcomes, but they have provided an indication of need. Very few providers have moved to contracts that reward quality and outcomes.

Two new payment models were proposed for adult care in 2016/17 (for 2017/18). One is based on the year of care or episode of care appropriate to each of the mental health care clusters. The second is a capitation-based payment tied to care clusters or similar data. Both link payment in part to quality and outcome measures. There is now further consideration for the use of a blended payment approach whereby a fixed ('block') payment, set at a level intended to reflect the efficient cost of delivering forecast activity, is combined with a variable payment to manage the risk of activity variance from plan, and/or a financial risk share element, sharing outturn surpluses or deficits across partner organisations, to promote collective management of financial risk by the system and incorporate an element of payment linked to locally agreed quality and outcomes measures. We understand many of the ICSs and ICPs are thinking about moving to this blended approach.

Outcomes can measure effectiveness, patient safety and patient and carer experience. Alignment between national and local measures, as well as clarity on purpose, supports the reliable and systematic collection of outcome measures. Outcome measures cannot simply be an add-on to a standard clinical interaction. This would be perceived by many as a top−down approach and an experience that is difficult to implement. Instead, there are other key principles to follow that will help support the use of routine outcome measures in mental health.

Outcome measures should be: clinically relevant; reflective of what people who use the service (and their families and/or carers) want; culturally-appropriate and culturally-reliable; aligned with system-wide objectives; and measurable using metrics with established reliability and validity. They should not introduce a heavy bureaucratic burden. There should be a strong emphasis on co-production which will enable the development of a common, shared vision and can lead to system-wide buy-in, which may support the achievement of outcomes.

Vision

➢ By 2021/22, remove perverse incentives from the current mental health payment system by ending the use of unaccountable block contracts and move to outcomes-based payments, as set out in the FYFVMH.
➢ By 2023/24, the culture in the NHS should allow clinicians to collect and report patient outcome measures routinely.
➢ By 2023/24, data collection should be streamlined to reduce clinical burden while also improving clinicians' access to key information and allowing people who use the services to drive the system by being empowered to self-monitor.

Essential actions

- NHSE and NHSI to end the use of care clusters as the basis for payment and replace with a payment system underpinned by patients' journeys through services, rewarding and incentivising step-down care, in the least restrictive setting. These care journeys will include access standards, where these are developed, to drive achievement of improved access to timely, evidence-based care with routine outcome measurement. The majority of patient care is delivered within community settings, and future payment systems need to be able to accurately consider the costs in this setting. There is much concern about the burden on clinicians from using care clusters and any replacement must reduce this administrative burden.
- NHSE and NHSI to ensure that where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental health care, the payment approach should be embedded within the wider urgent and emergency care payment approach and payment for mental health care within physical care pathways should be similarly integrated. Within a 'whole population budget,' a new payment mechanism is needed to maximise the success of fully integrated ICS, and careful consideration is needed of how mental health spending is fairly calculated.
- NHSE should expand the national CQUIN programme to include additional initiatives on mental health and, at a local level, this should be used to contribute an element of risk/gain share arrangements against some of the key local system metrics. Ideally, this would also be matched by making a benefit pool available via the Better Care Fund. This would incentivise partners to work together against a set of core outcomes, which should include mental health-related indicators, such as overall bed days for people with dementia, depression and SMI.
- NHSE should carefully design the CQUIN programme so that NHS trusts are able to sustain the positive changes to services, even when there is no longer a CQUIN specifically attached.
- NHSE and NHSI to ensure both national and local outcome measures are used as part of the payment system.
- NHSD and NHSE to invest in greater digital technology to improve the efficiency of collecting outcome measures and empower patients to play a role in their own care.
- NHSD and NHSE to encourage greater working between digital suppliers and clinicians to help improve the interface between outcome measures and EPRs.
- All STPs/ICSs/ICPs to include mental health metrics in local evaluations of new models of care that reflect outcomes, activity and quality of provision.

Data and transparency

In becoming one of the most transparent health systems in the world, the inadequacy of good mental health data needs to be urgently addressed.

Vision

- ➤ By 2023/24, the quality of mental health services and the extent to which they are meeting the needs of the local population will be demonstrated through the provision of accurate, relevant, timely data which will be collected routinely for each person with mental health problems receiving care.

Essential actions

- DHSC should take a leadership role and work with NHSD to develop a 10-year data plan for mental health. This plan should include how data will be used to promote patient choice, efficiency, access and quality in mental health care, as well as ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor/in early stages of development or collection) to drive improvements in services.

- NHSE, NHSI, HEE and NHSD should commit to publishing the Mental Health Dashboard every quarter and include trust-level data and workforce data to create a more comprehensive picture of opportunities and challenges at commissioner, provider and STP/ICS levels.
- NHSD must make routine data available so that there is transparency about how local areas commission services that account for age, gender, ethnicity, disability and sexuality.
- NHSD should improve access to mental health data while ensuring the necessary safeguards are in place.
- NHSE should require CCGs to publish data on levels of mental health spending in their Annual Report and Accounts by condition and per capita as well as broken down by service types, such as CAMHS and older adult mental health services. These reports should be externally audited at year end and made publicly available.

Governance and accountability

The FYFVMH set out a number of recommendations for governing the delivery of the strategy, including:

1) appointing a Senior Responsible Officer (SRO) responsible for overseeing the delivery of the FYFVMH in the NHS, working with all partner organisations
2) developing a cross-ALB Mental Health and Dementia Programme Board, chaired by the SRO, bringing together accountabilities for delivering the NHS elements of the programme through executive-level attendees from all key delivery partners, including the National Clinical Director for Mental Health, to coordinate and track progress against plans. This board reports in part to the cross-ALB FYFV Board
3) establishing an Independent Advisory and Oversight Group that advises the Board and acts as the panel supporting development and delivery of the mental health dashboard and CCG Improvement and Assessment Framework (IAF). This group is chaired by the former chair of the Mental Health Taskforce and includes a range of external stakeholders
4) working with a Mental Health Performance and Delivery Group (PDG) including representatives from NHSE's regional teams and NHSI who work closely with providers and commissioners. Regional support and activity is coordinated through the PDG and regional mental health governance infrastructure, which is owned by regional NHSE and NHSI colleagues and varies regionally, and
5) setting up Clinical Reference Groups that support the delivery of NHSE's specialised commissioning function, by bringing together experts to advise on service specifications and procurement needs to meet the demand for these services.

It appears these governance mechanisms have been successful, and we suggest these continue once the Long-Term Plan is in place. However, we suggest three specific alterations to the governance arrangements to enhance transparency and accountability.

First, joined-up leadership and governance across Government departments have not been in sync with the governance systems set up within NHSE. For instance, the Inter-Ministerial Group for Mental Health has worked thematically, discussing topics of particular relevance or interest at that moment. While this is useful, we also suggest a project management style approach akin to that used by NHSE, which would allow DHSC to scrutinise the implementation of both NHS and cross-government recommendations. These processes should be aligned more strategically, presenting opportunities to identify solutions to shared challenges that might lie outside the NHS. Performance data and an assessment of progress made – both success and failures – should be reported publicly every year to (i) raise awareness of the changes being implemented, (ii) inspire public confidence and (iii) operate in a transparent way.

Second, over the course of the FYFVMH, ALBs have reported challenges of differing scales and complexities (e.g. HEE's workforce challenges, NHSD's data challenges etc.) but the barriers have not always been addressed in a comprehensive and joined up way, which has affected the delivery of the entire programme. NHSE should have stronger levers to ensure mental health programmes across other ALBs are being implemented as agreed and any barriers are promptly addressed.

Third, the success of the FYFVMH is often susceptible to changes happening in other health policy areas, such as the recommendations associated with the GP FYFV, work to improve care for people with long-term conditions as well as the drive to meet efficiency targets, to name a few. The NHS Long-Term Plan presents an opportunity for mental health improvements to be comprehensively integrated across other relevant programme areas, making mental health everyone's business and breaking out of silo working. This should be reflected in the Plan itself and in any joint integrated governance arrangements. As such the 'NHS Assembly' should consist of leaders with expertise in mental health from national, clinical, patient and staff organisations, the voluntary, community and social enterprise sector, as well as NHS ALBs and frontline leaders from ICSs, STPs, trusts, CCGs and local authorities.

Vision

➢ By the end of 2018/19, there is greater transparency and public accountability for the delivery of the FYFVMH and the NHS Long-Term plan.

Essential actions

- NHSE should have stronger levers to ensure mental health programmes across other ALBs are being implemented as agreed and any barriers are promptly addressed.
- DHSC to review the terms of reference of the Inter-Ministerial Group for Mental Health to ensure it has full oversight and accountability of both NHS and cross-government recommendations.
- DHSC and NHSE to publish an annual report on the implementation of the current FYFVMH and the Long-Term Plan once implemented.
- NHSE to ensure the 'NHS Assembly' consists of leaders with expertise in mental health from national, clinical, patient and staff organisations, the voluntary, community and social enterprise sector, as well as NHS ALBs and frontline leaders from ICSs, STPs, trusts, CCGs and local authorities.

This chapter has set out proposals for the formation of integrated care systems and providers; payment, outcomes and other system levers; data and transparency; and governance and accountability. The next chapter outlines a fair funding model for delivering the ambitions described in this paper.

16. Fair Funding

> **As a patient:**
> 'Mental health services in my area get a fair share of NHS funding so that I get the same high standard of care as people in other parts of the country. Preventative care and early intervention services are available to me, so I can get help earlier rather than when I am really unwell.'
>
> **As a clinician:**
> 'I can work with my colleagues to deliver services that meet the needs of people in my area because services in my area get a fair share of funding and we are paid appropriately for the support we provide. I am accountable, but I don't have to waste time that should be spent with patients on needless paperwork. I am empowered to work with colleagues to deliver early interventions and preventative care.'

This chapter sets out a fair funding model for delivering the ambitions described in this paper, including NHSE's revenue and capital spending on mental health, and DHSC's budget.

The Prime Minister's announcement for an average 3.4% rise in NHSE's spending on health each year is welcome and this funding boost will go a long way to putting mental health services on an equal footing with physical health.

Historically, mental health services have been underfunded compared to other areas of the health service. Over the course of the 2010−2015 Parliament, funding for 43 NHS trusts that provide mental health services were found to have fallen by 8.25% in real terms.[125] The FYFVMH set out plans to increase mental health funding up to 2020/21, with £1.28 billion more than in 2015/16 pledged to be invested in mental health services for children, adults and older adults. It is vital that commissioners fulfil their existing financial commitments and are responsive to the changing demographics of our society in which people are living longer than ever before.

Revenue and capital spending on mental health

As we have already argued, delivering the ambitions set out in this paper will require 70,348 more staff working in mental health services by 2028/29 (excluding the 8,000 staff working in Mental Health Support Teams being rolled out nationwide in schools over that period).

These staffing costs, as well as capital funding, have been independently costed by NHS Midlands and Lancashire Commissioning Support Unit to ascertain the NHS investment in Mental Health required between 2019/20 and 2028/29, as per a multi-year funding settlement and 10-year workforce plan.

Vision

If the workforce increase was maintained at an even pace from 2021/22 to 2028/29, the financial implications would be:

➤ Between 2019/20 and 2023/24, invest an additional **£5.957bn** (£5.435bn revenue and £521m capital) in mental health services. This increase in revenue expenditure equates to at least a 50.8% growth in resources from 2017/18. It will take spending by CCGs and NHSE on mental health from 10.82% in 2017/18 to around 12.16% of the total NHS England budget.

➤ Between 2024/25 and 2028/29, invest an additional **£7.647bn** (£6.711bn revenue and £936m capital) in mental health services. This increase in revenue expenditure equates to at least a 37.5% growth in resources from 2023/24. It will take spending by CCGs and NHSE on mental health from 12.16% to around 13.10% of the total NHS England budget (if this was to rise by 3% above inflation year-on-year).

We have also modelled an alternative workforce trajectory, whereby 20,000 of our proposed increase in nursing and midwifery, scientific, therapeutic and technical staff and clinical support staff is front-loaded for the period up to and including 2023/24. At the same time, our planned increase in psychiatrists would be back-loaded towards the latter half of the decade to enable more time for the necessary infrastructure to be put in place around training and development. This would have the following implications for the funding:

➢ Between 2019/20 and 2023/24, invest an additional **£6.198bn** (£5.677bn revenue and £521m capital) in mental health services. This increase in revenue expenditure equates to at least a 52.8% growth in resources from 2017/18. It will take spending by CCGs and NHSE on mental health from 10.82% in 2017/18 to around 12.32% of the total NHS England budget.

➢ Between 2024/25 and 2028/29, invest an additional **£7.456bn** (£6.520bn revenue and £936m capital) in mental health services. This increase in revenue expenditure equates to at least a 36.0% growth in resources from 2023/24. It will take spending by CCGs and NHSE on mental health from 12.32% to around 13.13% of the total NHS England budget (if this was to rise by 3% above inflation year-on-year).

The proposals herein, therefore, imply an overall investment by NHSE of **£10.1 billion at an even pace of workforce growth or £10.2 billion with the alternative model** by 2028/29 in cash terms and an investment of **£0.9 billion** in capital for the DHSC. The NHSE element includes provision for capital spend on maintenance and infrastructure, drawing on advice from our independent economist.

If the front-loaded workforce model was adopted, this would mean that the funding uplifts required for delivery would be in the range of 5.5% to 6.8% above inflation for the period up to and including 2023/24. Spending growth could then slow slightly to between 4.3% and 4.6% above inflation for the remainder of the period to 2028/29, with the majority of workforce commitments by then in place.[126]

We recognise there is an ongoing need to drive efficiency gains and reduce variation across the system. NHS efficiency requirements remain at 2% per annum, which should be factored in as a service improvement rather than a cash reduction in mental health services.

The methodology and sources for costing this analysis are presented in Appendix 3.

Costing of proposals for additional physical health checks

The most recent estimate of the cost of the national NHS Health Check programme in 2015/16 was £450m, providing just over 1.4m checks at a unit cost of £320 per check delivered.[127] Assuming therefore that the cost would be equivalent for a check for a patient with SMI, the amount required (net of cost inflation) to increase coverage in SMI patients from 60% to 90% by 2028/29 would be approximately £73m.

Vision

➢ Invest £73m to expand the national NHS Health Check programme to reach 90% of people with SMI by 2028/29.

The most likely savings resulting from health checks would be achieved through reductions in emergency admissions for LTCs or admissions related to lifestyle factors and therefore represent the opportunity cost of not increasing and achieving the target.

As an indication of some of this cost there is an 'excess' (difference in age and sex-standardised rates) of £332m worth of ambulatory care sensitive admissions in mental health services users, £12m admissions related to smoking and £36m of admissions related to obesity above and beyond the levels seen in the non-mental health service-user population in England.[128]

Essential actions

- NHSE should continue to mandate that CCGs meet the Mental Health Investment Standard, which should continue to mean that investment in mental health rises at a faster rate than their overall programme funding. The standard should also be adjusted to include specialised commissioning spending.
- NHSE should carefully target additional funding to ensure local areas have the resources and understanding of where new monies for mental health should be invested. This is particularly crucial in children and young people's services and older adult services.
- Building on the early success of the new models in tertiary mental health services spanning Child and Adolescent Mental Health Tier 4, adult secure and adult eating disorder services, NHSE should continue to offer these options to commissioners and providers.

Department of Health and Social Care budget (TDEL)

Like many health services, mental health is intrinsically linked to social care and public health and is an essential element of support, helping recovery and independence and preventing costly crises. Cuts to local authority budgets are limiting the scope of mental health social care, just as they are affecting public health provision. This is particularly impacting on older people and the services providing them with support. In turn, this is putting extra pressure on individuals, families and the NHS.

Vision

➢ Ahead of the next spending review, the Government should commit to a rise in DHSC's budget (TDEL) by at least 3% per annum in real terms to avoid cuts to key areas of spending such as public mental health, capital investment and education and training.

This chapter has outlined a fair funding model for delivering the ambitions set out within this paper, including NHSE's revenue and capital spending on mental health, and DHSC's budget.

17. Conclusion

This paper has set out the College's proposals for change for the Long-Term NHS Plan with supporting policy recommendations, workforce solutions and the necessary funding commitments.

In doing so, we call on DHSC, other relevant government departments, NHSE, the other ALBs of the NHS, and relevant organisations to:

1. Commit to the biggest expansion in access to mental health services across Europe, empowering the disempowered with a much-needed focus on tackling inequalities, fit for a modern NHS.
2. Enable the NHS to become the safest, most effective, and transparent health system in the world with mental health trusts leading the way.
3. Empower mental health leaders to develop the healthcare services of the future through Integrated Care Systems and Providers.
4. Build a strong and resilient mental health workforce with 70,348 more staff on the ground by 2028/29 (excluding Mental Health Support Teams), of which 4,218 will be psychiatrists.
5. Invest an additional **£6.198bn** (£5.677bn revenue and £521m capital) in mental health services between 2019/20 – 2023/24 and a further **£7.456bn** (£6.520bn revenue and £936m capital) between 2024/25 – 2028/29. This will take spending by CCGs and NHSE on mental health from **10.8%** in 2017/18 to around **13.1%** in 2028/29 of the total estimated NHS England budget. This would mean that the funding uplifts required for delivery would be in the range of **5.5% to 6.8%** above inflation for the period up to and including 2023/24. Spending growth could then slow slightly to between **4.3% and 4.6%** above inflation for the remainder of the period to 2028/29, with the majority of workforce commitments by then in place.

The College has modelled these proposals on the foundation of the FYFVMH strategy, where more people are accessing treatment for their mental ill health than ever before. However, support for people with mental health problems has long been underfunded and undervalued and still only one in three people with a mental health condition receive treatment. As a result, it is too often the case that people become more ill than they need to, recover more slowly than is necessary, and die earlier than they should from preventable physical health problems, with the inevitable cost to human happiness, family life, jobs and the economy.

Developing a Long-Term Plan between July and mid-late autumn is a significant challenge, but with real opportunities to accelerate transformation in mental health and working more closely with other parts of the health and care system. The College hopes to continue to be a key partner in shaping this agenda over the coming months and to be involved in its implementation.

It is clear that the vision to achieve parity of esteem between mental and physical health is within our grasp. People can and do recover from mental ill health and over the next 5−10 years, we can make extraordinary progress towards addressing this imbalance and improve the lives of people living with a mental illness.

Appendix 1: RCPsych's Vision for Mental Health Services by 2023/24 and 2028/29

Programme, priority and enabler	Vision
Prevention, Personal Responsibility and Health Inequalities	**Tackling inequalities in mental health provision** ➢ By 2023/24, everyone who uses mental health services should have equitable access to effective early interventions and equitable experiences of care and outcomes, regardless of age or ethnicity. ➢ By 2023/24, there will have been a year-on-year reduction in the disparities between people from Black, Asian and minority ethnic groups and the rest of the population, in terms of both numbers of people detained under the Mental Health Act 1983 and the range of appropriate treatments offered including alternatives to detention. ➢ By 2023/24, LGBTQ+ services are expanded as well as outreach services to deprived children, young people and families, hard to reach groups and those from Black, Asian and minority ethnic communities. ➢ By 2023/24, people at risk of discrimination, and protected groups under the Equalities Act subject to the Mental Health Act have access to an advocate with specialist knowledge of legislation to advocate appropriately for them. ➢ By 2023/24, mental health tribunal panels better reflect the communities they work with.
	Preventing poor physical health and reducing premature mortality ➢ By 2028/29, 90% of people on the SMI primary care register will receive physical health checks (727,312) in primary care. ➢ A 20% reduction in the national suicide rate between 2021/22 and 2028/29. ➢ Continue with the aspiration for 'zero suicides' in NHS inpatient settings among people receiving specialist mental health care. ➢ By 2023/24, all NHS trusts can identify deaths that warrant an investigation and put in place a process to learn from them in cases where a patient had been receiving treatment and support for their mental illness, with a particular focus on people 'at risk' such as those who are from a Black, Asian and minority ethnic groups.
	Population health management ➢ All STP/ICS/ICP leaders to employ population health management approaches with sufficient consideration for mental health and wellbeing. ➢ All STP/ICS/ICP leaders to develop a system-wide outcomes framework, including mental health and wellbeing outcomes, which defines the partners' collective ambition for improving outcomes for people living in the area, which should be then used to monitor performance against the outcomes framework annually. ➢ By 2028/29, all 'Healthy New Towns' to include within their plans a priority to promote good mental health and wellbeing of their population and improve access to health services for people of all ages with mental ill health. Dementia-friendly communities should be a fundamental part of the design.
Healthy Childhood and Maternal Health	**Perinatal, parental mental health and early years mental health services** ➢ By 2023/24, expand perinatal and early years mental health services within Universal Services (maternity services, health visiting, Sure Start centres and primary care).

	➤ By 2023/24, antenatal classes should universally include information about mental health and wellbeing, as well as parenting, and Parenting Programmes. ➤ Between 2021/22 and 2028/29, Community Perinatal Mental Health Services should continue to support women in the perinatal period and increase the paternal mental health support made available. ➤ Between 2021/22 and 2028/29, maintain the same access rate to evidence-based specialist mental health care for women with an SMI during the perinatal period as is planned for the end of the FYFVMH. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.
	Children and young people's mental health services ➤ By 2023/24, 45% and by 2028/29, 70% of children and young people with a diagnosable mental health condition will be accessing integrated treatment and support, through IAPT, Mental Health Support Teams in schools, and CAMHS with appropriate waiting times. ➤ By 2028/29, an equivalent model for Crisis Resolution and Home Treatment Teams (CRHTTs) will be developed, which should be multi-agency (including social workers) and adapted to meet the needs of children and young people. ➤ By 2028/29, a 4−6 week waiting time will have been implemented for access to specialist NHS children and young people's mental health services, building on the expansion of specialist NHS services already underway. ➤ By 2028/29, there will be developmentally informed services for children and young people up until the age of 25 years, and this should be appropriately resourced between child and adolescent and adult mental health services. ➤ By 2028/29, every school and college will have identified a Designated Senior Lead for Mental Health to oversee the whole-school approach to mental health and wellbeing. ➤ By 2028/29, all Mental Health Support Teams will have received training to be equipped with the ability to identify the mental health needs of vulnerable groups of children and young people – such as young people not in education, employment or training (NEETs), children with neurodevelopmental problems (including Attention Deficit Hyperactivity Disorder [ADHD], autism spectrum disorders [ASD] and intellectual disabilities), children with long-term health conditions, children with behavioural difficulties, looked-after-children, young carers, refugees and migrant children, children with a first language other than English, children in the criminal justice system, abused children, LGBTQ+ young people – and to refer them appropriately.
Primary Care	**Primary mental health care** ➤ By 2023/24, invest in new forms of mental health support as a central component of enhanced models of primary care, so that primary care teams are better equipped to address the wide range of mental health needs in general practice (including among people presenting primarily with physical symptoms), and to address the physical health needs of people with mental health problems. This will need to be done in a way that is aligned with wider efforts to transform primary care to ensure that it is sustainable. ➤ By 2023/24, ensure that local integrated care teams can make full use of mental health expertise in supporting people with complex and ongoing care needs, with mental health staff (community psychiatric nurses, nurse therapists and psychologists), including those with expertise in older people's mental health, enabled to input proactively into all case discussions and offer advice and training to the wider team.

	➢ By 2023/24, all primary care services should accept dual GP registrations for students and be able to manage care in a coordinated way.
	➢ By 2028/29, 50% of people with common mental disorders can access psychological therapies each year.
	➢ By 2028/29, the choice of therapies available in the IAPT programme is expanded across all mental health diagnoses.
	➢ By 2028/29, parity of access to IAPT services is delivered for older people (who are significantly less able to access psychological therapies by dint of frailty and multimorbidity) and people with an intellectual disability. Services need to comply with equality legislation by making a reasonable adjustment to their services to facilitate people with an intellectual disability using IAPT services.
	➢ By 2023/24, primary care services routinely offer social prescribing, where appropriate.
	➢ By 2023/24, primary care services employ wellbeing coordinators (or similar) to support people with mental health problems, and other physical health conditions to access community resources.
Mental Health Care in the Community, Hospital and Specialist settings	**Mental Health assessment services**
	➢ By 2028/29, every STP should have First Response Services (or a similar model) that directs 111 callers to 24/7 support and mental health crisis response. The service should consist of: experienced psychological wellbeing coaches who provide initial assessment via telephone; a coordinator who oversees the coaches and coordinates calls from emergency services; and first responders (mental health nurses or social workers) who provide face-to-face assessment and crisis management.
	➢ By 2028/29, every police control room should have a mental health practitioner present in order to improve the care people receive when in contact with the police.
	➢ By 2028/29, all areas of the country should use Street Triage service staffed by police officers, paramedics and mental health nurses.
	➢ By 2023/24, end the use of police vehicles to transport people with a mental illness to a place of safety, except in exceptional circumstances.
	➢ By 2023/24, end the use of police cells as a place of safety for adults, as is currently the case for children and young people, except in exceptional circumstances.
	➢ By 2023/24, 65% of acute hospitals and/or paediatric departments provide access to a Core24 liaison psychiatry service and 100% by 2028/29. These teams should include psychiatrists with expertise in older adults.
	➢ By 2028/29, integrated in and outpatient services include liaison psychiatry to meet the needs of patients with more complex problems.
	➢ By 2023/24, 100% of acute hospitals have a protocol for the management of severe malnutrition in patients with anorexia nervosa.
	Community mental health services
	➢ By 2028/29, 100% of community mental health services are meeting a defined set of recommended NICE guidelines and more staff are able to give continuity of support to a larger number of patients with SMI to prevent relapse, hospitalisation and the use of the Mental Health Act 1983.
	➢ By 2023/24, there will be a Community Rehabilitation and Recovery team in every mental health trust and the right complement of Rehabilitation inpatient services in order to avoid the use of 'locked rehab' units.
	➢ By 2023/24, access to mental health support (incl. IAPT) for older people will be on par with services available to working-age adults.

➢ By 2023/24, all settings in which older people with mental health issues are resident will have easy access to a mental health support team that includes the services of a specialist in old age psychiatry.

➢ By 2023/24, a system to be in place for regular communication/cooperation between primary care, old age psychiatric services and social care to synchronise care delivered to older adults.

➢ By 2023/24, social care teams, managers of residential and care homes with nursing, GPs, patients and their carers will have clear pathways for providing initial and continuing care for mental health issues.

Other specialist teams

➢ By 2023/24, 95% of adults with an eating disorder who require urgent treatment should start this within one week and the same proportion with routine cases should be commencing treatment within four weeks.

➢ By 2028/29, there will be a dedicated community eating disorders service, which is integrated with medical care and supports a seamless transition from children and young people's services to adult care and from inpatient care to reduce the length of stay.

➢ By 2023/24, people with complex mental health problems, including personality disorder, should have greater access to a range of evidence-based psychotherapies tailored to their needs.

➢ By 2023/24, the principles of reflective, psychologically minded practice and enabling environments underpin training of professionals and delivery of integrated models of care in community and inpatient settings across physical, mental health and social care.

➢ By 2028/29, every STP will have NHS specialist addictions services led by appropriately trained and experienced addiction psychiatrists. This should include adequate provision for children and young people and older adults experiencing addictions.

➢ By 2023/24, more veterans will be able to access NHS mental health services (TILS and CTS) with an initial face-to-face assessment within 2 weeks and a first clinical appointment, where appropriate, 2 weeks thereafter. There should also be a greater focus on increasing services available to female veterans.

Mental health crisis and acute services

➢ By 2023/24, 75% and by 2028/29, 85% of people experiencing a first episode of psychosis start treatment with a NICE-recommended package of care with a specialist EIP service within 2 weeks of referral.

➢ By 2028/29, 100% of specialist EIP provision is graded at level 4, in line with NICE recommendations.

➢ By 2020/21, CRHTTs across England will have a 24/7 community-based mental health crisis response in all areas of the country and these teams will be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. These services then need to receive sustained investment after 2020/21.

➢ By 2023/24, these CRHTTs should incorporate a model specifically to meet the different needs and risks of older adults (particularly in relation to co-morbid physical health issues) and that these teams will be adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.

➢ By 2028/29, patients can expect to wait a maximum of 4-hours for admission to an acute psychiatric ward or acceptance for home-based treatment following assessment, for those who need it.

➢ By 2028/29, all patients are followed-up within 48 hours of discharge, rather than 7 days, as this reflects the evidence-base for preventing suicide post-discharge.

- ➢ By 2028/29, the availability of psychological therapies accessible in secondary, tertiary care and specialist settings to be substantially increased. For children and young people with more complex issues, they should access more specialised therapies if first and second line IAPT treatments have failed.
- ➢ By 2028/29, building on the current ambition to eliminate inappropriate external placements, trusts to eliminate inappropriate internal (within home provider) placements.
- ➢ Between 2019/20 and 2028/29, 85% bed occupancy in mental health trusts is consistently achieved.
- ➢ By 2028/29, there are more places to receive support during a mental health crisis as an alternative to an admission to hospital. This should be extended to include children and young people and older adults and should not be limited to care homes in the case the latter.
- ➢ Between 2019/20 and 2023/24, the average NHS trust score for 'continuity of care' in the CQC's community mental health survey should improve year-on-year, with no trust posting a decline.
- ➢ By 2023/24, all patients in contact with mental health services have a simple goal-orientated care plan as well as a personalised safety plan including an agreed set of activities, strategies, people and organisations to contact for support if they become suicidal.
- ➢ By 2023/24, every person who is having suicidal thoughts or has started self-harming should have a Safety Plan. These plans need to include explicit reference to the removal of means of suicide or self-harm and need to set out actions which are proportionate, timely and clinically meaningful.
- ➢ By 2028/29, redesign what is meant by aftercare, including reforming eligibility criteria to improve equity of access, resolving some of the complex arrangements across health and social care, especially regarding funding.

Secure services and offender healthcare
- ➢ Between 2020/21 and 2028/29, the Liaison and Diversion services set up through the FYFVMH should continue to provide multi-agency assessment and referral service within police custody and the courts across England, but they should also hold cases on a short-term to prevent people falling through the net.
- ➢ Solitary confinement (defined as more than 22 hours in segregation without meaningful human contact) should be banned immediately for children and young people in the youth justice system.
- ➢ By 2023/24, the Community Sentence Treatment Requirement testbed sites pilot, currently being rolled out by the MOJ and DHSC, will be expanded to include better secondary care provision, to allow for those with more severe mental illnesses to benefit from community sentences.
- ➢ By 2028/29, 70% of adults receive dedicated mental health screening within 24−48 hours after entering the prison and 70% of people who need treatment or support are followed up within a month.
- ➢ By 2025/26, establish a minimum ratio of prison officers to prisoners (to provide basic safety of prisons, and protect from dangerous, mind-altering drugs and for prisoners to access mental health services in prison), and recommend an urgent assessment of how to better attract and retain a prison mental health workforce, including forensic psychiatrists, to deliver mental health care.
- ➢ By 2023/24, all young people identified as 'in need' by youth justice liaison and diversion workers have an appropriate service they can be referred to.

	➢ By 2023/24, the integrated care project (also known as 'SECURE STAIRS') will be completely rolled-out and evaluation of the project will be published to that lessons can be learned for future joined-up approaches.

Intellectual Disability and Autism	➢ By 2028/29, all STPs have:
	   ○ specific mental health care pathways that cover the lifespan of people with an intellectual disability, autism or both.
	   ○ GP-held registers for intellectual disability and autism.
	➢ By 2028/29, there is a significantly reduced reliance on inpatient services for people with an intellectual disability.
	➢ By 2028/29, the average life expectancy of people with an intellectual disability is extended.
	➢ By 2028/29, community services for adults and children with an intellectual disability are significantly enhanced.

Integrated and Personalised Care for People with Long-Term Conditions and Older People with Frailty (including Dementia)	**Integrated and personalised mental health care for people with long-term conditions** ➢ Between 2018/19 and 2020/21, integrated psychological therapy services for people with medically unexplained symptoms and long-term physical health conditions are rolled out across all CCGs. These services then need to receive sustained investment after 2020/21. ➢ By 2023/24, everyone admitted with acute complications of diabetes whose aetiology is unclear or not medically explained is screened for mental illness and staff are appropriately trained to do this. ➢ By 2023/24, all patients prescribed second-generation antipsychotics are screened for diabetes. **Dementia care** ➢ By 2028/29, 90% of people with dementia should receive a timely diagnosis (increasing from 66.7% in 2018). ➢ By 2028/29, 90% of people with dementia are offered post-diagnostic treatment and support, which should be NICE-recommended, and the support needs should be outlined in the initial care plan. This care plan should be reviewed within at least 12 months of being agreed, then reviewed every 12 months in accordance with changes in the person's needs. Revisions should be jointly developed and agreed with the person (and, if applicable, their carer). ➢ By 2028/29, 90% of carers for people with dementia should also be offered post-diagnostic support and/ or a carer's needs assessment.
Cardiovascular Diseases, Respiratory Diseases and Cancer	➢ By 2028/29, the commissioning of any new cardiovascular or respiratory disease service must specifically consider the psychological needs of that population from the outset and ensure that appropriately skilled mental health professionals are integrated and supported to function within that service. ➢ By 2023/24, all patients on a cancer treatment pathway are referred to psychological and mental health support in the community, in a timely manner.
Workforce, Training and Leadership	➢ By 2028/29, the supply of staff in mental health services will be secured to deliver the ambitious set of improvements set out in chapter five in this plan. An additional 70,348 staff will be working in mental health services (excluding the 8,000 expected to be working within Mental Health Support Teams). From these staff, 4,218 will be psychiatrists. ➢ By 2028/29, all mental health organisations will be mentally healthy workplaces and considered as model modern employers offering flexible, accessible and valuable careers to people from all communities. ➢ By 2028/29, mental health professions will be widely considered as rewarding careers with excellent employment prospects as well as unique opportunities to make a difference in people's lives. ➢ By 2028/29, the introduction of new roles will be found to be effective and successful in improving mental health service provision and helping to provide continuity of care for patients.

	➤ By 2028/29, mental health professionals will be empowered to advocate for mental health across the wider health and social care system.
Clinical Review of Standards	**Safe services** If the NHS is supported to build capacity in the system through a commitment to increase the workforce and increase capital funding: ➤ 43% of mental health trusts will be rated as good or outstanding on safety by 2023/24 and 60% by 2028/29 – an improvement from 27.8% in September 2018. ➤ 81% of mental health trusts will be rated as good or outstanding for being well-led and 90% by 2028/29, with none rated as inadequate by 2023/24 – an improvement from 75.9% and 3.7% respectively in September 2018.
	Effective services ➤ By 2023/24, 72% of mental health trusts are rated as good or outstanding for effectiveness, with this percentage rising to 80% by 2028/29. ➤ By 2023/24, more people using mental health services in the community, inpatient settings and IAPT services have a positive experience of care and the underlying reasons for differences in access (including access to evidence-based NICE-concordant treatments) and experiences between different groups are identified and addressed.
Digital and Technology	**Better use of technology and digital solutions** ➤ By 2023/24, there is a step-change in the use of technology in mental health settings, building on the learning from the Global Digital Exemplars, Test Beds and the Internet of Things. ➤ By 2028/29, telepsychiatry is used routinely across all mental health settings, where appropriate. ➤ By 2028/29, the care pathway under the Mental Health Act is digitised to adopt a standardised approach and support enhanced system-wide information flow, developed through co-production.
	Modern electronic patient records ➤ By 2028/29, IT systems are interoperable between all health providers, primary and secondary care, and between themselves and providers of social care. ➤ By 2028/29, EPR systems provide a modern solution that supports high quality, safe and cost-effective mental health care that meets the needs of the end-user. They support efficient input of clinical data, pathway management, evidence-based care and outcome measurement, and have an open application programming interface (API) to enable clinicians to develop and connect innovative software solutions to improve patient care and outcomes.
Research and Innovation	➤ By 2028/29, there is fair and equitable funding of mental health research drawing on the ROAMER priorities. ➤ By 2028/29, the decline in academic psychiatry posts will have been reversed with a 50% increase in Clinical Senior Lecturer posts ➤ By 2028/29, every medical school will have an academic department of psychiatry with psychiatry being taught effectively to all medical students.
System Architecture	**Integrated Care Systems and Providers: empowering mental health leaders to develop the healthcare services of the future** ➤ By 2019/20, every ICS will have mental health reflected as a top priority with the full programme delivery supported and tracked at ICS board level.

	➢ By 2019/20, every ICS will have a mental health investment strategy, signed off by the ICS board and in place across partners in the ICS, including:
	    o plans for the use of additional mental health funding in baselines for each mental health deliverable and meaningful delivery of the Mental Health Investment Standard;
	    o quality assurance of mental health delivery, including evaluating the value and return on investment of mental health programmes to facilitate forward planning; and,
	    o agreement across the health system that efficiencies delivered through mental health initiatives will be reinvested back into mental health services to promote sustainability.
	➢ By 2019/20, every ICS will have a credible workforce plan to demonstrate how it will be meeting the mental health priorities of the local population.
	➢ By 2023/24, senior mental health leadership will be a core component of all place-based planning, including STPs, ICSs, ICPs and any other new model of care.
	➢ By 2023/24, there is greater leadership from managers, particularly middle managers, to tackle the culture of bullying and harassment in the NHS.

	Payment, outcomes and other system levers ➢ By 2021/22, remove perverse incentives from the current mental health payment system by ending the use of unaccountable block contracts and move to outcomes-based payments, as set out in the FYFVMH. ➢ By 2023/24, the culture in the NHS should allow clinicians to collect and report patient outcome measures routinely. ➢ By 2023/24, data collection should be streamlined to reduce clinical burden while also improving clinicians' access to key information and allowing people who use the services to drive the system by being empowered to self-monitor.
	Data and transparency ➢ By 2023/24, the quality of mental health services and the extent to which they are meeting the needs of the local population will be demonstrated through the provision of accurate, relevant, timely data which will be collected routinely for each person with mental health problems receiving care.
	Governance and accountability ➢ By the end of 2018/19, there is greater transparency and public accountability for the delivery of the FYFVMH and the NHS Long-Term plan.
Fair funding	**Revenue and capital spending on mental health** ➢ Between 2019/20 and 2023/24, invest an additional **£6.198bn** (£5.677bn revenue and £521m capital) in mental health services. This increase in revenue expenditure equates to at least a 52.8% growth in resources from 2017/18. It will take spending by CCGs and NHSE on mental health from 10.82% in 2017/18 to around 12.32% of the total NHS England budget. ➢ Between 2024/25 and 2028/29, invest an additional **£7.456bn** (£6.520bn revenue and £936m capital) in mental health services. This increase in revenue expenditure equates to at least a 36.0% growth in resources from 2023/24. It will take spending by CCGs and NHSE on mental health from 12.32% to around 13.13% of the total NHS England budget (if this was to rise by 3% above inflation year-on-year).

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	Costing of proposals for additional physical health checks
	➢ Invest £73m to expand the national NHS Health Check programme to reach 90% of people with SMI by 2028/29.
	Department of Health and Social Care budget (TDEL)
	➢ Ahead of the next spending review, the Government should commit to a rise in DHSC's budget (TDEL) by at least 3% per annum in real terms to avoid cuts to key areas of spending such as public mental health, capital investment and education and training.

Appendix 2: RCPsych's Essential Actions for Organisations

	Actions	Responsible organisation
Prevention, Personal Responsibility and Health Inequalities		
Tackling inequalities in mental health provision	To appoint a team of equalities champions with a specific remit to tackle mental health inequalities across the health system and through cross-Government action.	DHSC
	To introduce an obligation in primary legislation to reduce inequalities, including amending the statutory duties placed on CCGs, NHSE, local authorities and the Secretary of State. This should include: - an explicit requirement to assess the gap between people with mental health problems across the spectrum accessing health and care services and the rest of the population - a plan to improve and/or integrate services to close this gap year-on-year, and - an explicit requirement on the Secretary of State for Health and Social Care to assess how well NHSE has fulfilled these legal duties and respond publicly each year.	Government
	To commission high-quality research on the impact of racism on mental health in line with a national research priority-setting exercise.	DHSC
	To raise literacy on the impact of racism and ageism on mental health, and to provide leadership in implementing preventive interventions and actions.	DHSC, working with other government departments, professional bodies (including the medical Royal Colleges), charities, patients and carers
	To establish a 'Health and Social Care Observatory' to monitor, track implementation and report on the impact of policy and practice on the mental health of patients, including Black, Asian and minority ethnic groups.	DHSC
	To prioritise the implementation of the patient and carer race equality standard currently being developed by the National Collaborating Centre for Mental Health (NCCMH). This should include setting up monitoring and reporting processes for all trusts.	NHSE
	To ensure that health and care professionals receive diversity and equality training and promote effective training for NHS organisations to monitor and address factors that put Black, Asian and minority ethnic groups at a disadvantage.	NHSE, working with the medical Royal

		Colleges and other organisations
	To involve people from Black, Asian and minority ethnic groups as well as older people in all aspects of their organisation, including service co-production, planning and delivery of care. They will need to ensure that patients involved in these activities receive appropriate training, development and support.	Mental health trusts and other trusts providing mental health services across England, with support from commissioners and other partners
	To ensure all government policies, whether new or existing, are assessed for their impact on mental health with findings published ahead of any changes being made and revisited every 2 years.	Government
Preventing poor physical health and reducing premature mortality	To review the data collection for excess mortality and commit to a quarterly publication.	NHSE, working with NHSD
	To include severe and enduring eating disorders (SEED) in the SMI register. CCGs to then commission services that deliver comprehensive physical health assessments and follow up care to people with SEED.	NHSE
	To support and resource the 'Equally Well' initiative, which will be producing a Charter for Equal Health in autumn 2018.	DHSC
	To produce an annual suicide prevention plan assessed against assurance measures to be developed by PHE, DHSC and the Ministry of Housing, Communities and Local Government (MHCLG) and report on their progress to reducing suicides at the end of each year. This should be overseen by a national implementation board.	Every local area
	To implement and resource a self-harm and suicide prevention competence framework, due to be published in 2018, for a wide range of professionals working in education, police and housing.	NHSE PHE
	To roll-out the 'Learning from Deaths' tool produced by the College's Centre for Quality Improvement (CCQI), which support trusts to respond to concerns about any aspect of their care; and provides trusts with guidance on using individual reviews to consolidate learning identified using the tool. RCPsych will collate reviews, perform thematic analyses to identify learning points, and report these back nationally.	NHSE RCPsych
Population health management	To publish national and local evaluations of new models of care (vanguard sites), including an assessment of their impact on people with mental health problems as well as on mental health and wellbeing-related outcomes across the wider population.	NHSE Local leaders
	To provide local systems with guidance and examples of good practice, demonstrating how population health approaches can help address mental health issues as well as wider public health problems.	NHSE
	To require all 'Healthy New Towns' to report on their progress to promote mental health and wellbeing (amongst other priority areas) annually and take action accordingly.	NHSE PHE

Healthy Childhood and Maternal Mental Health		
Perinatal, parental mental health and early years mental health services	To develop a national Perinatal, Parental Mental Health and Early Years Mental Health Strategy.	DHSC MHCLG NHSE PHE HEE
	To provide greater investment in support for teenage mothers and their children, given the high rates of mental health problems in teenage and young mothers.	DHSC MHCLG
	To develop services for pregnant and postnatal women with underlying personality disorders, and services for women with substance use disorders.	NHSE
	To ensure CCGs sustain their investment in new/existing specialist community perinatal mental health teams developed during the FYFVMH period.	NHSE
Children and young people's mental health services	To implement the proposals in the Children and Young People's Green Paper in full, and the forthcoming prevalence survey should be reviewed and taken into consideration. DHSC and DfE should view this as a starting point and commit to building a more ambitious second phase.	DHSC DfE
	To develop a new model of support for looked after and previously looked after children.	DHSC
	To review the availability of services for children and young people with neurodevelopmental disorders and their families, from early diagnosis and post-diagnostic support, through to specialised services and a good transition to a developmentally-appropriate service.	NHSE
	To roll out the New Care Models in Tertiary Mental Health programme to support more appropriate local provision through joint commissioning between NHSE and providers so that children and young people in need of inpatient beds access a bed close to home. Within this programme, children and young people, should not be admitted to tier 4 beds due to lack of appropriate social care provision, including specialised community placements.	NHSE
	To implement the recommendations of their review of children and young people's mental health services in full.	CQC and other partners
	To fund new Mental Health Support Teams in schools, supervised by NHS children and young people's mental health staff, to provide specific extra capacity for early intervention and ongoing help.	CCGs
	To develop a robust integrated pathway of care for children and young people with an intellectual disability and/or autism and a mental health condition, covering services throughout their lifetime. This pathway should focus on strengthening support in the community by building on the provision of preventative support and early intervention programmes (including evidence-based parent training programmes), and a range of support and training for families and carers.	NHSE
	To publish an evaluation of how the Green Paper proposals affect vulnerable groups of children.	Government

Primary care		
Primary mental health care	To ensure that mental health is a core component of all work being developed in multispecialty community providers (MCP), primary and acute care systems (PACS) and primary care homes as part of an STP, ICS or ICP.	NHSE
	To strengthen mental health capabilities in the primary and community health workforce by improving the confidence, competence and skills of GPs (including for children and young people's mental health issues), integrated care teams and others, as well as making the best use of community pharmacists. Similarly, aim to strengthen the physical health competencies of mental health professionals.	HEE
	To ensure equality in the NHS Constitution, as currently, patients do not have the right to access the majority of mental health treatments and therapies, even though they are NICE-approved, because they are not classed as a 'technology'.	DHSC
	To review the current exclusion criteria for accessing IAPT services and consider the factors affecting the number of people who do not complete treatment.	NHSE
	To develop a strategy to reduce the gap in access between older adults, Black, Asian and minority ethnic groups, students and any other group not currently served well by IAPT services.	NHSE
	To extensively map assets and resources within the community, with due consideration of mental health and wellbeing resources. The ease in which patients can access these resources (with a particular focus on excluded groups), and the ease in which primary care professionals can refer to them, should be regularly reviewed.	Every primary care service
Mental health in Community, Hospital and Specialist settings		
Mental health assessment services	To commit to act on the recommendations of the Independent Review of the Mental Health Act 1983 and provide local areas resourcing support as needed.	Government DHSC NHSE
Community mental health services	To publish and implement the findings of their Community Mental Health Services Project.	NHSE and NCCMH
	NHSE to link co-production and continuity of patient care to payment through CQUINs, with an emphasis on the least restrictive care.	NHSE
	To consider the findings from the North-East London Foundation Trust's national multi-centre Open Dialogue pilot.	NHSE
	To work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.	MHCLG, DHSC and other agencies
	To ensure every STP has Individual Placement and Support (IPS) services and there is fidelity to the model.	NHSE
	To develop new models to support older people with mental health issues in the community, moving beyond the model that depends on memory clinics.	DHSC

	To develop a preventative strategy including initiatives to reduce the incidence of loneliness along with other factors that are known to reduce the risk of mental illness in older people.	PHE NHSE
	To commission specialist mental health services for older adults with appropriate provision of these services, tailored to the local health demographics. Examples include care home liaison services and community dementia teams supporting patients and their carers.	CCGs
	To have older adult expertise in crisis care, either by bespoke teams or with dedicated older adult expertise in 'all-age' crisis support.	Mental health trusts
Other specialist services	To introduce access and waiting time standards for adult eating disorder cases, in line with the benchmarks in place for children and young people.	NHSE
	To review the existing quality and capability of adult eating disorder services to achieve parity with child and adolescent mental health services.	NHSE CQC
	To develop a national commissioning strategy across NHSE (Tier 4 to 6) and CCGs (Tier 1 to 3) for services for people with a personality disorder to ensure that an appropriate pathway of care, with the provision of specialist services, is available in all geographical areas.	NHSE
	To co-produce a national quality framework and service specification for tier 4 personality disorder services and a robust method of evaluating the effectiveness of service delivery. In addition, tier 2, 3, 5 and 6 PD services should be subject to a national quality framework and robust methods of evaluating the effectiveness of service delivery, developed by CCQI.	NHSE, service users, carers, clinicians and voluntary sector organisations
	To thoroughly review the commissioning of addiction services, including a review of potential service models, with consideration of reinstating the NHS as lead commissioners or mandating addiction services within local authority budgets.	DHSC and MHCLG
	To continue the Life Chances Fund for outcomes-based interventions to tackle substance use disorders.	The Cabinet Office
	Should TILS and CTS prove successful (as measured by standard recovery/improvement metrics), to consider using this model as a blueprint for the development of other culturally-sensitive mental health services for important occupational groups who are known to be at risk of occupationally-related mental ill health. Examples include NHS staff, teachers and emergency services.	NHSE
	To commission research into the effectiveness of IPS services for veterans in improving vocational rehabilitation outcomes.	DHSC
Mental health crisis and acute services	To undertake a service capacity assessment and improvement programme to ensure that they have an appropriate number of beds as well as sufficient resources in their CRHTTs to meet the need for rapid access to high-quality care.	Commissioners, providers and clinical networks in each area
	To commit to act on the recommendations of the Independent Review of the Mental Health Act 1983 and provide local areas resourcing support as needed.	Government DHSC NHSE

	Building on the National Collaborating Centre for Mental Health's review of the CPA, to replace it with a shorter, meaningful plan for everyone in contact with mental health services, rather than those only recognised as needing additional support.	NHSE
	To conduct an annual survey of experiences of people receiving care in inpatient mental health settings, as is already being done in physical health services. As part of this, the CQC should develop high-quality measures that feedback can be taken from carers of those people unable to directly comment on their experiences of the inpatient care.	CQC
Secure Services and Offender Healthcare	To sustain investment in community forensic mental health services and roll out new co-commissioning funding and service models as set out in the FYFVMH.	Commissioners
	To mandate Offender Healthcare services to collect and report patient-level mental health activity data every quarter.	NHSE NHSD
	To fund a training strategy for health, social care and criminal justice professionals working with people with fund a training strategy for health, social care and criminal justice professionals working with people with personality disorder.	DHSC MHCLG MoJ
	To instruct the wider use of Mental Health Treatment Requirements with community sentences as an alternative to imprisonment in appropriate cases, at primary, secondary and tertiary health service provision, and early evaluation of proposed test bed sites.	DHSC MoJ
	To trial Approved Premises as an alternative to remand prisons for those awaiting trial.	MoJ
	To review the availability of short-term accommodation for those released from prison with a mental health problem and report no later than 2019.	MHCLG
	To develop a national strategy for assessing and treating ADHD in the criminal justice system given the strong evidence of links between ADHD and offending and reductions in reoffending with drug treatment.	DHSC MoJ
	To review the commissioning of prison mental health services to ensure sustainable, high-quality services and the provision of access to old age specialist advice, given the ageing prison population.	NHSE
Intellectual disability and autism		
	To review the implementation of the national service model for people with an intellectual disability and/or autism who display behaviour that challenges, including those with a mental health condition, and report no later than 2019.	NHSE LGA ADASS
	To refresh the Transforming Care strategy in light of developing health and social care structures, which will come to an end in 2019, and seek to embed its ethos in current practice more widely.	NHSE
	To fund innovations to ensure less reliance on inpatient services.	NHSE
	To support recruitment to all professions working with people with intellectual disability and include education on people with intellectual disability in all curricula.	HEE

Integrated and Personalised Care for People with Long-Term Conditions and Older People with Frailty, including Dementia		
Integrated and personalised mental health care for people with long-term conditions	NHSE to develop robust integrated pathways of care for long-term conditions that address psychosocial needs, including the management of co-morbid mental illness. Psychiatric expertise (particularly Old Age psychiatrists) is required for the assessment and management of complex cases and should be built into the pathway.	NHSE
	To reconsider its current strategy, which separates physical and mental health recommendations in their guidance.	NICE
	To develop joint pathways that incentivise integrated care through CQUINs. It is important that pathways are developed with input from specialist psychiatrists relevant for that group, such as pathways for child health and pathways for older adults. Consideration should also be given to third sector providers.	Acute trusts and mental health trusts
	To create a diabetes register, with immediate priority given to units where individuals may have prolonged inpatient admissions (for example secure hospitals).	Mental health trusts
	To audit current practices in diabetes care and consider: • the implementation of diabetes-related competencies as part of mandatory training with a particular focus on managing and avoiding hypoglycaemia and safe use of insulin • basic skills for staff in the management of diabetes and mental health that are in keeping with their job role to care for patients with comorbidity • awareness of local pathways and policies for contacting diabetes or mental health services, and • if best practice tariff criteria are met for diabetes ketoacidosis and hypoglycaemia and for children and young people with diabetes.	Mental health trusts
Dementia	To adhere to the Dementia Care Pathway.	CCGs Providers
	To assess the different levels of risk of developing dementia as well as specific needs, such as those with early-onset dementia, people from black, Asian and minority ethnic backgrounds and people with intellectual disabilities and capture this within their Joint Strategic Needs Assessment and local Dementia Needs Assessment.	CCGs
	To consider new models to support older people with mental health issues in the community, moving beyond the model that depends on memory clinics. This might incorporate a model whereby patients remain under the care of an Old Age psychiatrist from diagnosis until death, rather than being discharged back to a GP. This should involve regular check-ups and brief interventions when problems are identified. This aims to improve the quality of care provided, reduce hospital admissions and GP caseloads.	NHSE
	To consider the findings from the care home 'vanguard' pilots and review whether mental health input into care homes could be redesigned based on examples of good practice. A core part of this should	NHSE

	include ensuring care home staff are supported to provide better care, using a quality improvement methodology.	
Cardiovascular Diseases, Respiratory Diseases and Cancer		
Cardiovascular diseases, respiratory diseases and mental ill-health	To develop robust integrated care pathways of care for patients with cardiovascular and respiratory diseases that meet their psychosocial needs, including the management of co-morbid mental illness.	NHSE
	To reconsider its strategy on separating physical and mental health recommendations in their guidance.	NICE
Cancer and mental ill-health	To ensure the commissioning of any new cancer service must specifically consider the psychological needs of that population from the outset and that appropriately skilled mental health professionals are integrated and supported to function within that service.	NHSE CCGs
	To develop robust integrated care pathways of care for patients with cancer that meet their psychosocial needs, including the management of co-morbid mental illness.	NHSE
	To recommend the widespread commissioning of integrated cancer psychological support services in acute trusts and cancer centres, consisting of a stepped care approach to managing psychological distress as per NICE guidance – consisting of access to counselling, psychology and liaison psychiatry.	NHSE
	To ensure that all GPs are able to refer patients on a cancer treatment pathway to psychological and mental health support in the community, in a timely manner.	NHSE
	To commission services which should include primary care advice lines and prescriber support to GPs, led by psychiatrists with cancer care experience.	NHSE
	To recommend commissioning of inpatient cancer liaison psychiatry services consisting of at least some dedicated medical and nursing resource, in line with demand.	NHSE
	To liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences to significantly improve funding and support for integrated education and research involving cancer and mental health.	NHSE, HEE, NIHR, Medical Research Council and Wellcome Trust
Workforce, Training and Leadership: building a strong and resilient mental health workforce		
Implementing HEE's workforce plan, *Stepping Forward* in full	To ensure *Stepping Forward* is implemented in full.	HEE NHSE DHSC
Attracting students and doctors to choose psychiatry	To have plans in place to encourage more medical students to choose psychiatry.	All medical schools
	To commission an adequate and appropriate foundation and specialty training posts to support the increased cohort of medical school graduates and to ensure that: • at least 60% of doctors in the Foundation Programme do a high-quality four-month psychiatry post by 2023/24, and	HEE

	• at least 75% of doctors in the Foundation Programme do a high-quality four-month psychiatry post by 2028/29.	
Attracting pupils to choose a career in mental health	To fund a collaborative 'Mental Health Careers' campaign aimed at secondary school students, possibly teachers and parents.	Government
Recruiting from overseas	The Government to expand the list of shortage specialties (which currently includes old age psychiatry), to include specialties such as child and adolescent psychiatry (including child and adolescent consultant psychiatrists, higher trainees and SAS doctors in CAMHS).	Government
	To remove the cap on the number of doctors who can benefit from the MTI and extend the Tier 5 Visa from 24 to 48 months.	Government
Supporting and retaining trainees	To put in place a range of measures as set out in the *Supported and Valued* report. These include: • protection of the minimum of 1 hour of supervision per week with their psychiatric supervisor; • a minimum of one teaching session per week provided through a local programme or on a recognised MRCPsych course; • timely allocation of psychotherapy cases with protected time for clinical sessions and supervision.	Deaneries Mental Health Trusts
	To develop and implement measures to make psychiatry training and careers in the NHS more flexible and attractive including expanding credentialing.	HEE RCPsych
	To restore the CPD budget to its 2013 level of £300m per year as opposed to the current £90m. A substantial proportion should be ring-fenced for mental health that is in line with the size of the mental health workforce, with an additional sum to reflect past disparity.	HEE
	To increase the number of trust-supported academic activities and safeguard academic sessions, as an important tool for recruitment and retention.	HEE
Supporting and retaining existing staff	To implement the mental health core and enhanced standards as recommended in Thriving at Work: the Stevenson/Farmer Review of Mental Health and Employers.	Mental health employers
	To implement the recommendations made by the Commission on the Wellbeing and Mental Health for Staff and Learners in the NHS (led by Sir Keith Pearson), due to be published by 31st December 2018	HEE, NHSE, DHSC and other relevant organisations
	To embed wellbeing measures as part of its methodology	CQC
	To set a yearly 4% improvement target in retention rates to be met by: • 50% of mental health trusts, and community and acute trusts where they are providing mental health services by 2023/24. • 100% of mental health trusts and community and acute trusts where they are providing mental health services by 2028/29.	NHSI
	To fund a pilot programme to test paid sabbaticals for senior mental health professionals.	HEE
	To urgently review tax penalties to prevent the loss of highly-skilled and experienced senior mental health professionals.	Government

Encouraging highly-skilled staff to return to practice in the NHS	To urgently review revalidation rules and process post-retirement to address the challenges faced by retired psychiatrists.	GMC
	To review psychiatrists' job plans to ensure they are adequate for retired psychiatrists who want to return to practice.	Employers
Recruiting and retaining Physician Associates in mental health	To call for at least 10% of the 1,000 PAs being trained each year to work in mental health (including liaison services and GP practices) from the 2019/21 intake onwards.	Government
	To accept and implement the recommendations made by HEE's task and finish group on PAs.	Government
Promoting mental health leadership	To work with its members to grow mental health leaders of the future, with a particular focus on gender and ethnic diversity of leadership.	RCPsych
	To establish a Future Mental Health Leaders programme led by the NHS Leadership Academy, in partnership with professional bodies such as RCPsych, building on the similar 'Future Clinical Commissioning Leaders' programme. They should promote leadership courses to middle managers who are underrepresented in the Leadership Academy.	HEE
Clinical Review of Standards		
Safe services	To fairly apportion additional capital funding to mental health trusts based on STP estates and capital plans.	DHSC NHSE
	To fairly apportion future revenue growth to ensure mental health trusts are able to meet and surpass national access and outcome targets, reduce inappropriate out-of-area placements and train staff to deliver a world class service.	NHSE
	To significantly increase and enhance the quality improvement support available to mental health trusts to enhance their safety and quality.	CQC NHSI
	To continue to work together to provide bespoke improvement and support offer to all trusts.	CQC NHSI
	To fairly apportion future Provider Sustainability Funding to mental health trusts.	NHSI
	To continue to implement its current strategy, which should be reviewed and extended in 2021, to: - move to a more responsive inspection model which is proportionate, and risk-based so that areas which require improvement or inadequate receive more attention, reflected through the frequency of inspections; - use the information they have about a service to focus inspections on specific services – such as maternity care – rather than the whole provider; and - build an in-depth and shared understanding of the local context and the quality of services, particularly across developing care structures, with inspectors, providers, commissioners and partners.	CQC
Effective services	Building on the early success of the GIRFT programme, to expand the programme to cover other mental health services, such as community services for adults and older adults; personality disorders; as well as	NHSI

	intellectual disability services, for example. The proposed new regional structure across NHSE and NHSI will need to be implemented at pace to help providers achieve this.	
	To mandate all mental health services to participate in a quality improvement network to help them monitor and improve the quality of the care that they offer.	NHSE NHSI
	Building on the learning from the acute care collaboration model in the West Midlands, to support the roll-out to other mental health trusts, where appropriate.	NHSE NHSI
	To implement Lord Carter's recommendation to expand and extend benchmarking data for mental health services on the Model Hospital, so trusts can identify efficiency and productivity opportunities.	NHSI
	As recommended by Lord Carter, to help strengthen commissioning and contracting mechanisms for mental health services by supporting providers and commissioners to work together within STPs/ICSs to develop model frameworks for specifications of services.	NHSE
Digital and technology		
Better use of technology and digital solutions	To invest in testing new technologies to investigate which are most practical and effective in the NHS.	DHSC NHSE
	To provide greater investment in digital infrastructure to ensure innovative technology functions smoothly.	DHSC NHSE
	To invest in training to raise the digital literacy of the NHS workforce.	HEE
Modern electronic patient records	To allocate capital funding for improvement in IT hardware and software in mental health trusts.	DHSC
	To work with primary care practices so that all Summary Care Records include vital mental health information, where individuals consent for their information to be shared.	NHSD
	To provide core administrative support for consultants to improve clinical productivity.	Trusts
Research and innovation		
World-leading mental health research	To commission regular prevalence surveys for adults (with the next report no later than 2023) and for children and young people (with a report, following the one due in 2018, no later than 2023).	DHSC
	To fund a follow-up survey to track the outcomes of the care received by the children and young people in the prevalence survey who have given informed consent. This will allow researchers to align findings and track data against better-developed indicators to help the Government better plan for the next ten years. It would also provide necessary information about what happens to children and young people over time.	DHSC
	To ensure that eating disorders are recognised within both prevalence surveys, after being excluded from the most recent iteration of the APMS.	DHSC
	To host a Mental Health Research Summit in 2019 that draws on the Grand Challenge and ROAMER programmes.	Government
	To liaise with other interested parties such as RCPsych, the Academy of Medical Royal Colleges, the Academy of Medical Sciences and other relevant stakeholders to provide required funding and support to develop careers of academic psychiatrists.	NHSE HEE NIHR

		Medical Research Council Wellcome Trust
	To address significant barriers in clinical academic career pathways in mental health research, and to provide greater support for post-doctoral research fellowships, the transition to academic clinical lecturer and establishment at senior lecturer level.	HEE
	To improve drug testing methodologies to include older people with co-morbidities. This might, for example, include ways of getting over issues of capacity by encouraging people to make future wishes statement on this issue whilst they still have the capacity.	MHRA
	To ensure that research in functional psychiatric illnesses should include older adults as a discrete group.	DHSC HEE
System Architecture		
Integrated Care Systems and Providers: empowering mental health leaders to develop the healthcare services of the future	To only approve the formation of an ICS/ICP if local system leaders have described a clear plan and commitment to achieve access and waiting time standards for mental health and the mental health workforce plan, and CCGs are meeting or exceeding the Mental Health Investment Standard. This should be part of a more sophisticated approach to assessing the performance of STPs and their readiness to progress to ICSs or ICPs as directed by a joint national transformation strategy.	NHSE
	In recognition of the significant benefits of, and need to expedite, integration of mental health and physical health services, to ensure at least one senior mental health leader in the programme management team is responsible for overseeing the implementation for each new model of care and involved in contract negotiations for ICPs. STP and ICS leaders should also engage or at least have input from specialists where the service encompasses a special group such as older people, children and young people, or those requiring specialised health services.	STP leads
	To always include people who use services.	Mental health leaders at an STP/ICS level
	To review all organisational mergers which include mental health services in the short- to medium-term given the lack of evidence of the associated impact, and in the long-term must require a comprehensive risk/benefit analysis	NHSE NHSI
	To rate each STP/ICS on their mental health plans, level of planned integration, and leadership representation (including people who use services) and support those that need further development. STPs/ICSs exceeding these core expectations should work with those who are struggling through a peer-learning approach.	NHSE NHSI
	To systematically capture and share learning from areas that are furthest ahead, including their governance arrangements and service models, to accelerate progress in other areas and to provide clarity about what is permissible within the current legal framework.	NHSE NHSI

	To assess the benefits and any unintended consequences of these structures compared with improving joint working through ICSs, including the scope of the draft Integrated Care Providers contract, particularly whether mental health services should be incorporated, either in a partially-integrated or fully-integrated capacity.	NHSE
Payment, outcomes and other system levers	To end the use of care clusters as the basis for payment and replace with a payment system underpinned by patients' journeys through services, rewarding and incentivising step-down care, in the least restrictive setting. These care journeys will include access standards, where these are developed, to drive achievement of improved access to timely, evidence-based care with routine outcome measurement. The majority of patient care is delivered within community settings, and future payment systems need to be able to accurately consider the costs in this setting. There is much concern about the burden on clinicians from using care clusters and any replacement must reduce this administrative burden.	NHSE NHSI
	To ensure that where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental health care, the payment approach should be embedded within the wider urgent and emergency care payment approach and payment for mental health care within physical care pathways should be similarly integrated. Within a 'whole population budget,' a new payment mechanism is needed to maximise the success of fully integrated ICS, and careful consideration is needed of how mental health spending is fairly calculated.	NHSE NHSI
	To expand the national CQUIN programme to include additional initiatives on mental health and, at a local level, this should be used to contribute an element of risk/gain share arrangements against some of the key local system metrics. Ideally, this would also be matched by making a benefit pool available via the Better Care Fund. This would incentivise partners to work together against a set of core outcomes, which should include mental health-related indicators, such as overall bed days for people with dementia, depression and SMI.	NHSE
	To carefully design the CQUIN programme so that NHS trusts are able to sustain the positive changes to services, even when there is no longer a CQUIN specifically attached.	NHSE
	To ensure both national and local outcome measures are used as part of the payment system.	NHSE NHSI
	To invest in greater digital technology to improve the efficiency of collecting outcome measures and empower patients to play a role in their own care.	NHSD NHSE
	To encourage greater working between digital suppliers and clinicians to help improve the interface between outcome measures and EPRs.	NHSD NHSE
	To include mental health metrics in local evaluations of new models of care that reflect outcomes, activity and quality of provision.	All STPs/ICSs/ICPs
Data and transparency	To take a leadership role and work with NHSD to develop a 10-year data plan for mental health. This plan should include how data will be used to promote patient choice, efficiency, access and quality in	DHSC

	mental health care, as well as ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor/in early stages of development or collection) to drive improvements in services.	
	To commit to publishing the Mental Health Dashboard every quarter and include trust-level data and workforce data to create a more comprehensive picture of opportunities and challenges at the commissioner, provider and STP/ICS levels.	NHSE NHSI HEE NHSD
	To make routine data available so that there is transparency about how local areas commission services that account for age, gender, ethnicity, disability and sexuality.	NHSD
	To improve access to mental health data, while ensuring the necessary safeguards are in place.	NHSD
	To require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts by condition and per capita as well as broken down by service types, such as CAMHS and older adult mental health services. These reports should be externally audited at year end and made publicly available.	NHSE
Governance and accountability	To have stronger levers to ensure mental health programmes across other ALBs are being implemented as agreed and any barriers are promptly addressed.	NHSE
	To review the terms of reference of the Inter-Ministerial Group for Mental Health to ensure it has full oversight and accountability of both NHS and cross-government recommendations.	DHSC
	To publish an annual report on the implementation of the current FYFVMH and the Long-Term Plan once implemented.	DHSC NHSE
	To ensure the 'NHS Assembly' consists of leaders with expertise in mental health from national, clinical, patient and staff organisations, the voluntary, community and social enterprise sector, as well as NHS ALBs and frontline leaders from ICSs, STPs, trusts, CCGs and local authorities.	NHSE
Fair funding		
Revenue and capital spending on mental health	To continue to mandate that CCGs meet the Mental Health Investment Standard, which should continue to mean that investment in mental health rises at a faster rate than their overall programme funding. The standard should also be adjusted to include specialised commissioning spending.	NHSE
	To carefully target additional funding to ensure local areas have the resources and understanding of where new monies for mental health should be invested. This is particularly crucial in children and young people's services and older adult services.	NHSE
	Building on the early success of the new models in tertiary mental health services spanning Child and Adolescent Mental Health Tier 4, adult secure and adult eating disorder services, to continue to offer these options to commissioners and providers.	NHSE

Appendix 3: Methodology and Sources Used for Costing

The HEE document, *Stepping Forward to 2020/21: the mental health workforce plan for England,* published in July 2017 is the prime document used for current manpower numbers broken down between different Transformation Programmes and other Core mental health services.

Proposals put forward by RCPsych for additional consultant numbers have been "uprated" to include other mental health staff in the same proportion of consultant to other staffing ratios that currently exist.

The analysis has been undertaken at 2017−18 prices and takes account of a number of assumptions about inflation, efficiency and demand to calculate the likely impact of these proposals on the proportion of national health resources devoted to mental health services.

Costs of grades of staff have been taken from NHSE estimates.

The proportion of pay to non-pay has been taken from statistics available from the Carter Model Hospital website.

Four elements of the analysis

There are four elements that have been combined to estimate the need for additional mental health spending over the next 10 years:

1. **HEE's proposals to increase mental health staffing by 2020-21 contained in the *Stepping Forward* plan.**

HEE has proposed that an additional 21,000 posts are recruited by 2020/21 to augment a current workforce of 194,000 as follows. The College has included proposals for an additional 218 non-consultant staff to be recruited in this period as part of our broader transformation plan.

TABLE 1. HEE'S PROPOSALS TO INCREASE MENTAL HEALTH STAFFING BY 2020-21 CONTAINED IN THE *STEPPING FORWARD* PLAN. NB – ROUNDING IN THE TOTALS AS REPORTED BY HEE

	Medical	Nursing & Midwifery	AHP & Scientific, Therapy & Tech	Support to Clinical Staff	Admin & Infrastructure	TOTAL
Children & Young People MH	200	1,200	700	2,200	200	4,400
Adult IAPT	0	0	2,900	1,600	0	4,500
Perinatal MH	100	500	200	400	0	1,100
Crisis	0	4,600	200	2,300	200	7,200
Liaison MH	300	400	-100	-100	300	600
EIP	100	1,200	200	700	0	2,600
Liaison & Diversion	0	300	0	0	0	400
RCPsych Proposal for additional non-consultant staff	218					218
TOTAL TRANSFORMATION	918	8,100	4,200	7,100	700	21,018

Based on the experience of recruiting additional consultants, it is estimated that 1,060 of these posts have been filled during 2017-18. It is estimated that the balance of these proposals will cost an additional £755m.

2. A proposal to reduce the number of vacancies in mental health posts.

Based on the HEE analysis of vacancies it would cost an additional £114m to reduce by a third the current medical vacancies, and reduce other staff group vacancies by 10%, recruiting an additional 2,350 staff to posts. It is recognised that these vacancies can only be filled through a combination of recruitment of new staff whilst improving retention of existing staff.

For the purposes of this analysis, it has been assumed that the vacancies are all funded.

3. Proposals specifically made by RCPsych to improve access to mental health services through investment in more consultant psychiatric posts and the required supporting staffing structures.

Proposals in several areas to increase the consultant and other staffing of mental health services would add an additional 38,740 staff to the workforce at a cost of £1,562m as follows:

TABLE 2. RCPSYCH'S PROPOSALS TO INCREASE THE MENTAL HEALTH WORKFORCE

	Medical	Nursing & Midwifery	AHP & Scientific, Therapy & Tech[129]	Support to Clinical Staff	Admin & Infrastructure	TOTAL
Children & Young Peoples MH Services	730	2,460	3,290	1,480	780	8,740
Perinatal MH Services	20	40	20	20	10	110
Liaison MH Services	440	1,580	100	100	170	2,390
EIP Services	80	580	290	220	120	1,290
Community MH Services	1,220	6,820	3,010	7,020	1,830	19,900
Old Age Services	180	1,000	440	1,030	270	2,920
Forensic Services	90	500	220	510	130	1,450
Addiction Services	30	170	70	170	40	480
Intellectual Disability Services	80	440	200	460	120	1,300
Medical Psychotherapy Services	10	60	20	60	10	160
TOTAL RCPsych PROPOSALS	**2,880**	**13,650**	**7,660**	**11,070**	**3,480**	**38,740**

4. Proposals to improve access to IAPT services by investment in AHPs and support staff.

Proposals to improve access to IAPT would add an additional 9,300 staff to the establishment at a cost of £334m as follows:

TABLE 3. RCPSYCH'S PROPOSALS TO INCREASE EXPANSION OF WORKFORCE FOR IAPT

	Medical	Nursing & Midwifery	AHP & Scientific, Therapy & Tech	Support to Clinical Staff	Admin & Infrastructure	TOTAL
IAPT Expansion 2021/22 to 2028/29			5,200	2,600	1,500	9,300
TOTAL EXPANSION OF IAPT	**0**	**0**	**5,200**	**2,600**	**1,500**	**9,300**

Summary Financial Position – additional revenue cost per annum by 2028/29 at current prices

Given assumptions that existing vacancies are funded, and that pay accounts for 72% of the total revenue bill, then the cost of these proposals would be an extra £3.8 billion per annum by 2028/29, or a 32% increase in mental health funding over a 10-year period, in real terms (not accounting for inflation), as follows:

TABLE 4. ADDITIONAL REVENUE COST PER ANNUM BY 2028/29 AT CURRENT PRICES

	2023/24	2028/29
	£m	£m
HEE Proposals	£755	£755
RCPsych Proposals	£586	£1,562
IAPT Expansion after 2021	£125	£334
Non-Pay	£568	£1,136
TOTAL REVENUE PER ANNUM	**£2,034**	**£3,787**

TABLE 4B. ADDITIONAL REVENUE COST PER ANNUM BY 2028/29 AT CURRENT PRICES – ALTERNATIVE WORKFORCE MODEL

	2023/24	2028/29
	£m	£m
HEE Proposals	£755	£755
RCPsych Proposals	£806	£1,562
IAPT Expansion after 2021	£125	£334
Non-Pay	£568	£1,136
TOTAL REVENUE PER ANNUM	**£2,269**	**£3,787**

By 2028/29 there would be a need for an additional 70,348 staff as follows:

TABLE 5. TOTAL ADDITIONAL MENTAL HEALTH STAFF REQUIRED BY 2028/29

	Medical	Nursing & Midwifery	Physician Associates	AHP & Scientific, Therapy & Tech	Support to Clinical Staff	Admin & Infrastructure	TOTAL
	WTE	WTE	WTE	WTE	WTE	WTE	WTE
HEE Proposals	858	7,900	0	3,750	6,900	550	19,958
Vacancy Reduction	480	770	0	290	530	280	2,350
RCPsych Proposals – MH services	2,880	13,650	800	6,860	11,070	3,480	38,740
RCPsych Proposals - Expansion of IAPT	0	0	0	5,200	2,600	1,500	9,300
TOTAL	**4,218**	**22,320**	**800**	**16,100**	**21,100**	**5,810**	**70,348**

This would represent an increase above the current workforce of 36% because a number of the existing vacancies would also be filled through this process.

Additional One-Off Costs

In addition to the on-going revenue costs of improved mental health services, there are several critical infrastructure, backlog maintenance and capital implications for mental health trusts, which amount to £1.3 billion as follows:

TABLE 6. ADDITIONAL ONE-OFF COSTS AT CURRENT PRICES

	2023/24 £m	2028/29 £m
Non-Recurring Investment		
Backlog & Critical Infrastructure	£276	£503
Capital	£219	£804
TOTAL NON-RECURRING INVESTMENT	**£495**	**£1,307**

Impact of inflation, pay and demographic changes

The additional costs of this bid have been uprated for the impact of inflation (in line with HMT forecast). A proposed additional real term pay award of 1% per annum for mental health staff to improve recruitment and retention and a 2% per annum forecast in demand for demographic change have also been costed.

This has the impact of increasing the proposal in cash terms to £4.8 billion by 2023/24 or £5.1 billion if our alternative workforce model is used and £11.1 billion by 2028/29 as follows:

TABLE 7. IMPACT OF INFLATION, PAY AND DEMOGRAPHIC CHANGE

	2023/24 £m	2028/29 £m
NHSE Funded Request		
HEE Proposals	£755	£755
RCPsych Proposals	£586	£1,562
IAPT Expansion	£125	£334
Non-Pay	£568	£1,136
Inflation on proposals	£231	£953
Real Pay Award - all staff	£535	£1,278
Demographic Growth	£1,499	£3,579
ANALYSIS OF RECURRING INVESTMENT	**£4,299**	**£9,596**
Backlog Maintenance (total)	£288	£549
TOTAL REVENUE	**£4,587**	**£10,146**
DHSC Funded Request		
Capital Spending (additional)	£233	£908
TOTAL SPENDING PROPOSALS	**£4,820**	**£11,053**

The proposals herein imply an overall investment by NHSE of £10.1 billion by 2028/29 in cash terms if the workforce increases steadily, or £10.2 billion if certain staff groups have front-loaded increases and for the DHSC an investment of £0.9 billion in capital. This is based on the advice from our independent economist that the proposed critical infrastructure and maintenance backlog investment will fall under the responsibility of NHSE to address.

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	2023/24	2028/29
	£m	£m
NHSE Funded Request		
HEE Proposals	£755	£755
RCPsych Proposals	£821	£1,562
IAPT Expansion	£125	£334
Non-Pay	£568	£1,136
Inflation on proposals	£240	£975
Real Pay Award - all staff	£539	£1,285
Demographic Growth	£1,509	£3,600
ANALYSIS OF RECURRING INVESTMENT	**£4,557**	**£9,647**
Backlog Maintenance (total)	£288	£549
TOTAL REVENUE	**£4,845**	**£10,196**
DHSC Funded Request		
Capital Spending (additional)	£233	£908
TOTAL SPENDING PROPOSALS	**£5,078**	**£11,104**

Proportion of NHS Resources spent on Mental Health Services

In 2017-18 it is estimated that mental health services account for 10.8% of NHSE's total revenue budget.

Whilst forward projections in the current economic climate are fraught, the following assumptions have been modelled to estimate the extent to which a relative investment in mental health services is being planned by 2028/29 if these proposals were adopted in full:

- NHS Inflation averages 1.85% per annum (GDP deflator to 2022/23, plus a 2% assumption thereafter).
- NHS resource growth over the period up to 2023/24 is as announced by the Prime Minister on 18 June 2018. Future modelling is predicated on a continued 5% uplift per annum including inflation to NHSE's budget.
- The impact of demographic growth on mental health services is 2.0% per annum because of the forecast growth in the size and age of the population, with a resultant increase in demand for mental health services.

On this basis it is estimated that if these proposals are adopted in full the proportion of NHSE's revenue resources invested in mental health services would grow to 13.1% by 2028/29 as follows:

TABLE 8. NHSE REVENUE AND RESOURCES INVESTED IN MENTAL HEALTH SERVICES

	2017/18	2023/24	2028/29
	£m	£m	£m
Mental Health Spending - proposed	£11,860	£17,885	£24,596
NHSE Estimated Resource DEL	£109,637	£147,112	£187,757
% Mental Health Spending	10.8%	12.2%	13.1%

	2017/18	2023/24	2028/29
	£m	£m	£m
Mental Health Spending - proposed	£11,860	£18,127	£24,647
NHSE Estimated Resource DEL	£109,637	£147,112	£187,757
% Mental Health Spending	10.8%	12.3%	13.1%

The forecasts though are very sensitive to the value of the variables. NHS Efficiency requirement remains at 2% per annum but should be taken as a service improvement rather than a cash reduction for mental health services.

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[94] When taking the commitments in HEE's *Stepping Forward* workforce plan*,* and the commitment to halve the vacancy rate into account, this equates to an 80% growth in the consultant psychiatrist workforce for children and young people.

[95] While acknowledging the Government is yet to report how Mental Health Support Teams will be organised, additional psychiatric staff will be required to meet an enhanced access target of 70%, implement a waiting time standard between 4-6 weeks, and provide oversight of the Mental Health Support Teams. These calculations also account for a modest adjustment for the forthcoming prevalence survey, which we predict is likely to show a rise in the proportion of children and young people with a diagnosable mental health condition from 9.6% (2004) to 13%.

[96] This represents a 12.5% growth in the consultant psychiatric workforce on top of the commitments in HEE's *Stepping Forward* workforce plan.

[97] The College suggest 500 additional consultant psychiatric posts is a minimum requirement alongside the development of new models of care that better support people closer to primary care, integrated with social care, and therefore allowing psychiatrists to work with smaller caseloads of people with more complex needs. Within this model, we include General Adult psychiatrists, Eating Disorder psychiatrists, Old Age psychiatrists and Rehabilitation Psychiatrists.

[98] This represents a 15% growth in the consultant psychiatric workforce on most recent NHSD data.

[99] This represents a 15% growth in the consultant psychiatric workforce on most recent NHSD data

[100] This represents a 25% growth in the NHS consultant psychiatric workforce (FTE) as reported in the RCPsych workforce census 2017. We also recommend a similar uplift in the number of consultant psychiatrists working in local authority funded drug and alcohol services, but data is unavailable to enable a precise estimate at this time.

[101] This represents a 15% growth in the consultant psychiatric workforce on most recent NHSD data.

[102] This represents a 15% growth in the consultant psychiatric workforce on most recent NHSD data.

[103] This breakdown includes the fulfilment of HEE's *Stepping Forwar*d plan and the filling of 160 vacant consultant posts out of the 240 planned for in the achievement of this vision.

[104] These estimates reflect the current composition of the non-consultant psychiatric workforce in NHS Digital. *NHS workforce statistics - May 2018. August 2018. Available from:* https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/may-2018 [Accessed 11 September 2018].

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[126] Planned mental health spending by NHS England and CCGs for 2018/19 has yet to be confirmed so our initial spending uplifts are based upon an estimated amount of £12.450bn. If more is ultimately invested in this year, then initial uplifts can be revised down and the range will be more like 5.5-6.5%.

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[129] This includes the 800 Physician Associate roles referred to in this document.

Contact

The College would be happy to provide further detail on any of the information contained within this paper and would welcome feedback on these proposals. We recognise this is an iterative process and, as such, we will be refining our recommendations over coming months as the policy and funding commitments become clear. You can find the version number and date on the front cover of this briefing.

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