

# NEXT STEPS FOR FUNDING MENTAL HEALTHCARE IN ENGLAND

A Comprehensive Settlement That Invests In  
Infrastructure, Prevention, People And Technology

**Executive Summary**

ROYAL COLLEGE OF PSYCHIATRISTS  
SEPTEMBER 2020

## 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.

## Executive summary

Ahead of the publication of the NHS Long Term Plan (LTP), we called on the Department of Health and Social Care (DHSC), NHS England & Improvement (NHSE/I), and other arm's-length bodies (ALBs) of the NHS to:

- 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
- enable the NHS to become the safest, most effective, and transparent health system in the world with mental health NHS trusts leading the way
- empower mental health leaders to develop the healthcare services of the future through Integrated Care Systems and Providers (ICS/ICPs)
- build a strong and resilient mental health workforce, and
- invest in mental health services so that spending on mental health by Clinical Commissioning Groups (CCGs) and NHS England rises from 10.8% in 2017/18 to around 13.1% in 2028/29 of the total estimated NHS England budget.<sup>1</sup>

The NHS Long Term Plan, underpinned by a revenue funding settlement of an extra £20.5bn for NHS England by 2023/24 (after inflation), included a commitment that mental health services will grow faster than the overall NHS budget – with a ring-fenced increase in investment worth at least £2.3 billion a year by 2023/24.<sup>2,3</sup> An ambitious programme of work is now underway to improve and transform mental health services in England, including a pledge to introduce waiting times standards for mental health.<sup>4,5</sup> This will take us some way to achieving parity of esteem between mental health, learning disability and autism services and physical health services, but there is a long way to go.

When novel coronavirus (COVID-19) was confirmed to have reached the UK in late January 2020, NHS services began to prepare for widespread transmission and declared a 'Level 4' National Incident.<sup>6,7</sup> The pandemic has impacted healthcare provision across the whole of the NHS and has placed major logistical challenges to research and education at a time of pressing need for both.

For mental health services, some of the expansion programmes have been expedited, such as: establishing 24/7, all-age, open access mental health crisis lines to support people with urgent mental health needs; the creation of mental health A&Es; increased use of digital and remote support technology; and the expansion of children and young people's eating disorder services.<sup>8</sup> At the same time, some mental health services were required to close or reduce their services (for staff absence or redeployment reasons), and some patients avoided seeking help for their mental health during the pandemic, particularly via A&E, primary care and to child and adolescent mental health services (CAMHS). The closure of schools will have likely had an impact on pupils receiving mental health support in those settings.<sup>9</sup>

The mental health consequences of COVID-19 are becoming increasingly evident. Clinicians are reporting increasing numbers of referrals from acute hospitals to liaison mental health services for patients with COVID-related mood and anxiety disorders (including PTSD) and non-delirium COVID psychosis, as well as lockdown-specific deteriorations in patients' mental health due to a lack of face to face contact – such as those experiencing psychosis, eating disorders or obsessive compulsive disorder, or depression prolonged by economic hardship or loneliness.<sup>10</sup>

As the NHS turns its attention to the restoration and recovery of healthcare services, we have argued, along with other healthcare leaders, for a rapid and forward-looking assessment of how prepared the country would be for a new widespread outbreak of COVID-19. While we acknowledge the future shape of the pandemic is hard to predict, local outbreaks are increasingly likely, and a second wave is a real risk.<sup>11</sup> Ensuring mental health services are prepared to manage patients with COVID-19 (both symptomatic and asymptomatic) while they are receiving treatment for their mental health, as well as prevent nosocomial

transmission of the virus, is essential. This is particularly crucial as we approach winter given the pressure that brings to the NHS and social care services. Concurrently, we need to ensure mental health services are prepared to deal with increasing numbers of patients needing treatment and support for their mental health. It is essential the NHS and social care system learn from the first wave of COVID-19 in order to better prepare for subsequent waves, while also adopting innovative new ways of working that have been identified in response to the pandemic.

The Prime Minister's recent announcement of £1.5bn for hospital maintenance, eradicating mental health dormitories, enabling hospital building, and improving A&E capacity is timely<sup>12</sup> as is the forthcoming Comprehensive Spending Review (CSR), which will set out the Government's spending plans for the parliament.<sup>13</sup> Mental health providers often receive a disproportionately lower amount of capital funding compared to other providers across the local health economy and none of the six hospital trusts given funding to develop a new hospital, or the 21 schemes given seed funding, were for mental health hospitals/facilities.<sup>14,15,16</sup> We are concerned that capital investment in mental health services will be limited to eliminating dormitory provision alone and mental health providers will lose out on further funding opportunities if concerted, targeted action is not taken.

As part of Government's commitment to achieve parity of esteem, we urge leaders to implement the recommendations set out in this briefing.

## **OBJECTIVE 1: Infrastructure – invest in mental health services fit for a modern, world-leading NHS**

We must invest capital funding into mental health and learning disability/autism services in order to:

- improve the resilience of mental health services, ensuring clinicians are prepared to manage patients with COVID-19 while they are receiving treatment and support their mental health, as well as preventing nosocomial transmission of the virus
- ensure the safety of patients and staff given the Care Quality Commission's (CQC) assessment that many mental health wards are unsafe and provide poor quality care in old and unsuitable buildings
- ensure the built environment supports patient outcomes and recovery, rather than hindering them
- ensure the built environment contributes to staff morale and increases retention, and
- ensure mental health trusts are able to contribute to the NHS' goal of providing sustainable healthcare, embedding nature within its service design.

**We call on mental health providers and CCGs to:**

1. review their estate and, if required, repurpose vacant property and/or procure and implement temporary modular facilities to increase real estate capacity during COVID-19 pandemic
2. replace dormitory accommodation with single en-suite rooms
3. improve the therapeutic environment of inpatient wards by eliminating mixed sex accommodation; procuring en-suite facilities for all existing single rooms, improving the built environment to minimise the risks of harm; and making the estate more suitable for people with disabilities
4. procure and/or develop property for clinical and office space for the LTP expansion programme; alternative age-appropriate crisis care provision; age-appropriate mental health assessment spaces in A&Es and acute hospitals; and new mental health ambulances/ transport vehicles
5. replace ageing buildings, and
6. clear the high and significant risk maintenance backlog in mental health and learning disability sites given the 158.4% rise over the last two years for high backlog costs alone.

For NHS mental health providers and CCGs to meet the six actions outlined above, the Government, DHSC and NHSE/I must commit to the following recommendations and areas of investment. Detailed costings are provided in Table 1.

## Recommendations

1. By 2024/25, DHSC and NHSE/I to provide a ring-fenced investment of **£3.34bn** (in current prices) to NHS mental health trusts (in addition to their day-to-day capital budgets) so they can, in the short-term reconfigure their existing estate through refurbishment, alterations and extensions to ensure mental health services are prepared and resilient to prevent nosocomial transmission of COVID-19 in these settings, and in the medium to longer-term, invest in transformational capital projects. This could be spread between COVID-19 costs, system-level allocations, and nationally allocated funding streams. When taking this proposed ring-fence investment of £3.34bn on top of mental health trusts' day-to-day capital budgets (based on trust budgets for day-to-day spending being at least maintained in current prices), the total investment over this period would equate to **£4.4bn**.

Specifically, our proposed ring-fenced investment could be funded from the recently announced capital injection for 2020/21 as well as the investment to be announced in the 2020 CSR (recommendations 2 and 3 below).

2. Of the £1.5bn nationally allocated capital funding for 2020/21, DHSC and NHSE/I to allocate and ring-fence a total **£375.9m** (25.1%) to mental health NHS trusts to meet the following commitments during this financial year:
  - a. NHS critical maintenance and emergency/A&E capacity (£100.9m [9.6%] of £1.05bn total allocation)
    - £68m to enable NHS mental health trusts to urgently reconfigure their existing estate in response to the COVID-19 pandemic, including acquiring temporary facilities (if required). NHSPS Taskforce should support mental health trusts leaders where necessary to procure and/or reorganise their estate as required
    - £12.9m to eradicate current high-risk maintenance backlog across mental health and learning disability sites/estates, and
    - £20m to begin to procure mental health ambulances/transport vehicles; create age-appropriate mental health assessment spaces in A&Es (or alternative) and acute hospitals; and begin to procure alternative forms of age-appropriate mental health crisis provision.
  - b. Modernising the mental health estate (£250m total allocation)
    - £250m to begin to eliminate dormitory provision and replace with single en-suite rooms.
  - c. Health Infrastructure Plan (£200m total allocation)
    - £25m of seed funding for the first five new major building and redevelopment schemes in mental health trusts. Decisions about which NHS trusts should be prioritised for seed funding for HIP projects should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads – potential trusts are detailed in the endnote.<sup>17</sup>

This investment should be taken as a down payment on plans to modernise the mental health estate for 2020/21 and beyond and to support delivery of the LTP and the recommendations of the Independent Review of the Mental Health Act, and should be on top of existing system-level allocations for 2020/21.

3. At the 2020 CSR, the Government, DHSC and NHSE/I to provide a ring-fenced investment of an additional **£2.96bn** to mental health NHS trusts between 2021/22 and 2024/25 as part of a multi-year capital settlement. This additional capital funding uplift should be in addition to trusts' day-to-day capital budgets and building on the momentum and previous targeted investment for 2020/21 as outlined above. This investment should include:
  - a. a new Health Infrastructure Plan (HIP) for Mental Health – for longer-term assets that support the NHS' delivery of world-class mental healthcare and the accompanying healthcare infrastructure that supports mental health outcomes. Within this,
    - £510m for the first instalment of a new £1bn building and redevelopment programme for Mental Health to enable six major building and redevelopment schemes to be awarded to mental health NHS trusts by 2024/25 (building on the proposed £25m of seed funding from 2020/21 and inclusive of a further £5m of seed funding for the sixth scheme), and with a commitment to deliver a further six mental health building and redevelopment schemes by 2030 (inclusive of a further £35m of seed funding). Decisions about which NHS trusts should be prioritised for seed funding should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads – potential trusts are detailed in the endnote<sup>18</sup>
    - £800m to improve the therapeutic environment of mental health and learning disability/autism inpatient settings by: eliminating mixed sex accommodation; procuring en-suite facilities for all existing single rooms; minimising the risks of harm through innovative safety improvement projects, and making the estate more suitable for people with disabilities
    - £350m to complete the elimination of dormitory provision and replace with single en-suite rooms
    - £600m for new building and redevelopment schemes for community mental health facilities, including clinical and office space, in order to deliver the confirmed objectives of the LTP up to 2023/24 and the expected further expansion of services in the remaining period
    - £100m for new building and redevelopment schemes for crisis mental health facilities, including the procurement of mental health ambulances/ transport vehicles; creating age-appropriate mental health assessment spaces in A&Es (or alternative) and acute hospitals; and procuring age-appropriate alternative forms of mental health crisis provision – building on the proposed investment of £20m during 2020/21.
    - £30m of capital funding for drug and alcohol use disorder services<sup>19</sup>
    - £250m to improve digital technology within mental health trusts, and
    - £160m for Research and Development in Mental Health and Dementia.
  - b. £160.88m to eradicate current significant and moderate risk maintenance backlog in mental health and learning disability sites/estates.
4. DHSC to allow mental health trusts to spend their planned capital budgets in full each year given the historic underinvestment. This should enable trusts to address ongoing backlog maintenance issues, maintain safe services and minimise risks across their estate.
5. NHSE/I and ProCure22 to provide a tailored package of support so that the six sites selected for the initial wave of the building and redevelopment programme for Mental Health can reach the stage of full business case approval by 2024/25.
6. Within the existing HIP programme, or where investment is being made for a new or upgraded acute hospital, DHSC, NHSE/I and local leaders to consider whether plans include sufficient space for

integrated mental and physical healthcare (liaison mental health services) to be delivered. This needs to be built into service design from the outset.

7. DHSC and NHSE/I to account for any pre-existing strategic capital schemes within their system-level capital allocations for the next financial year and beyond in order to avoid inadvertently reducing the capital funding available to individual trusts as a consequence. NHSE/I and DHSC should also make the formula used to calculate system-level capital budgets more transparent.
8. NHSE/I to ensure governance structures and accountability requirements for ICSs are more robust, given the move to shared decision making and negotiations between system partners for capital and estates planning and funding, with any arising issues resolved consistently across all systems.
9. NHSE/I and NHSD to require all providers of NHS mental health services to report an assessment of their current estate and report on their key gaps, risks and pressures and their contingency through a one off data collection exercise in response to the COVID-19 pandemic by 2020/21 year-end. This needs to include the community clinical estate as well as inpatient and crisis environments. This exercise should align with existing reporting mechanisms to reduce the burden on providers.
10. CQC and NHSE/I to extend their Use of Resources (UoR) assessment<sup>20</sup> to mental health providers, as this considers the value of trusts' backlog maintenance and how effectively it is managed; how efficiently the trust is using its estate and maximising the opportunity to release value; and the estates cost per square meter.<sup>21</sup>
11. NHSE/I and the CQC to extend the definition of mixed sex accommodation to include corridors and other shared spaces on the same ward.
12. All mental health trusts to adopt the sexual safety standards developed by the National Collaborating Centre for Mental Health and commissioned by NHSE/I by 2023/24.
13. As part of a Government-led Mental Health Safety initiative, NHSE/I to support mental health trusts so that 60% will be rated as good or outstanding on safety by 2023/24 and 75% by 2028/29 – an improvement from 47.1% in July 2020. CQC should also resume its normal functions as soon as possible and reintroduce a national mental health inpatient services experience survey to provide critical insight into people's experiences on inpatient wards during the pandemic and beyond.

## **OBJECTIVE 2: Prevention – protecting our mental healthcare system, ensuring it can cope with increasing**

It has previously been argued that the NHS has not reduced the total demand it originally proposed in the Five Year Forward View because of a lack of concerted effort in public health and prevention, poor resilience in social care and the lack of a parallel five-year budget for workforce growth, education and training.

Public mental health is about community cohesion and drawing on community resources in the widest sense. The COVID-19 pandemic has demonstrated the importance of this and the need to promote healthy lifestyles and prevent poor mental and physical health at the earliest opportunity.

We must increase the funding available to local government and the NHS to enable:

- local authorities to prepare and respond to increasing levels of mental distress and co-morbid physical health problems in the population due to COVID-19 and as a result of lockdown, which has caused anxiety and loneliness, amongst other issues
- mental health providers to prepare for an increase in demand for NHS mental health services (both planned and unplanned) as services deliver the ambitions of the LTP while also addressing a backlog of patients
- local authorities and the NHS to prepare for an increase in demand for drug and alcohol use disorder services given the way in which the pandemic has exacerbated these illnesses, and the reduced availability of some services during the peak, and
- local authorities and the NHS to prepare for an increase in demand for mental health social care support, given the need to discharge patients safely into the community with a package of care in place and for the impact the pandemic is having on children and young people and their families.

This needs to be underpinned by world-leading mental health research to identify preventative interventions, as well as cutting-edge treatments and therapies.

## **Recommendations**

### ***Public health funding***

1. At the 2020 CSR, the Government and DHSC to commit to increase the Public Health Grant budget<sup>22</sup> at least in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24, as part of a multi-year settlement, which will ensure local authorities can continue to provide prevention and public health interventions. Specifically, within this budget, local authorities to ring-fence at least 4% for public mental health spending, equating to a rise of 100%, or £70m, compared to 2018/19 figures, as the start of sustained and growing investment in this area.

This funding should be linked to the Joint Strategic Needs Assessments (JSNAs) for each locality and relevant local strategies. It should also align with the growth in the workforce of public mental health professionals and those working within voluntary, community and social enterprise organisations.

### ***Funding for mental health NHS services***

2. DHSC, NHSE/I and Health Education England (HEE), working with colleagues across the mental health sector, to undertake a review to assess whether investment into mental health services detailed in the LTP should be delivered over an accelerated timescale to support them to meet emergent demand. This needs to align with the growth in the mental health workforce.
3. Additionally, the Department for Education (DfE) and NHSE/I to urgently consider whether funding for mental health provision in schools should be delivered over an accelerated timescale, particularly as children and young people are due to return to their education in September 2020.

### ***Funding for drug and alcohol use disorder services***

4. At the 2020 CSR, the Government should commit to a real terms increase in the Public Health Grant<sup>23</sup> budget as part of a multi-year settlement, which will ensure local authorities can continue to:
  - a. work towards restoring total expenditure for adult substance use disorder services as a proportion of public health expenditure, aiming to get back to at least its 2013/14 levels of 29.9%, equating to a rise of £374m in current prices (based on 2018/19 figures), and
  - b. work towards restoring total expenditure for specialist drug and alcohol use disorder services for children and young people back to at least its 2013/14 level (2.4% of public health expenditure), equating to a rise of £43m in current prices (based on 2018/19 figures). This needs to be in line with the growth in addiction psychiatrists and the wider multidisciplinary team.
5. DHSC to allocate £30m of capital funding for drug and alcohol use disorder services by 2024/25.

6. DHSC and the Ministry of Housing, Communities and Local Government (MHCLG) to review the commissioning of addiction services, including potential service models, with consideration of reinstating the NHS as lead commissioners or mandating addiction services within local authority budgets.

### ***Funding for mental health social care support***

7. At the 2020 CSR, the Government, MHCLG and DHSC should commit to increase the social care budget for children, young people and adults to at least in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24.

Specifically, within this uplift, local authorities should commit to ring-fence funding devoted to early years, aiming to get it back to at least around 8% of the children's social care expenditure, equating to a rise of around £376m in current prices.

### ***Funding for mental health research***

8. DHSC to increase the funding for mental health research to 15% of the total UK research budget by 2030, drawing on the Roadmap for Mental Health Research in Europe (ROAMER) priorities and research associated with COVID-19.
9. DHSC to allocate £160m of capital funding to mental health trusts for Research & Development in Mental Health and Dementia including: the prevention agenda, research to improve the productivity and effectiveness of the NHS, and the translation of basic science and support for the life sciences industry by 2024/25.<sup>24</sup>

### ***Strategic planning and leadership***<sup>25</sup>

10. Government to establish a Mental Health Cabinet Committee to ensure collective responsibility for improving the mental health of the nation as part of the recovery from COVID-19.
11. Government to lead the development of a long-term, cross-government mental health strategy that runs alongside the NHS LTP. This should be closely aligned to the NHS mental health COVID-19 recovery plan developed by DHSC and reflect the increased mental health need as a direct consequence of COVID-19.
12. Government to extend the mental health representation within the Scientific Advisory Group for Emergencies (SAGE) and/or related sub-groups.
13. Government should ensure all government policies, whether new or existing, are assessed for their impact on mental health and health inequalities.
14. Government to appoint an Equalities Champion for Mental Health, Learning Disabilities and Autism to work across Government, reporting to the Cabinet Office Minister and with dedicated staff and resourcing.

Beyond funding, commissioning and strategic planning/leadership, our full set of recommendations for public health and prevention measures, managing capacity and demand, and research are included on pages 41-54.

## **OBJECTIVE 3: People – getting the NHS Long Term Plan back on track by investing in the mental health workforce, promoting diversity and supporting leaders**

When looking at the past three years of NHS Digital workforce data<sup>26</sup>, we might expect an additional 200 consultant psychiatrists to enter the workforce by 2023/24 against a requirement of 1,040 to deliver the LTP. Similarly, we think that fewer than 5% of the additional mental health nurses required to deliver the LTP will be added to the NHS workforce by 2023/24 if urgent action is not taken.

Delays to the Comprehensive Spending Review and the impact of the COVID-19 pandemic on international recruitment are the main reasons behind this poor outlook. As of September 2018, 46% of all NHS psychiatrists and 51% of consultant NHS psychiatrists in England had qualified abroad.<sup>27</sup> Recruiting from overseas is crucial for fulfilling workforce commitments required in the LTP.

Overseas doctors have long had crucial roles in delivering excellent patient care and we need to continue to support international medical graduates (IMGs) more than ever. However, the COVID-19 pandemic means that it would be both unsustainable and unethical to over-rely on international recruitment to get the workforce that we need. We must train more doctors here in the UK, which means we urgently need more medical school places and training placements.

There are reasons to be more optimistic. The number of full time equivalent (FTE) psychiatrists at all grades stood at 9,244.8 in May 2020, which represents a 3.2% increase on the same point in the previous year (8,961.8).<sup>28</sup> Capital investment in infrastructure and technology will make the NHS a more attractive place to work which will make a real difference in increasing staff retention.

At the Spending Round in 2019, the Government announced an increase of 3.4% in HEE's programme spending for 2020/21, including an additional £150 million for Continuing Professional Development (CPD). This will help provide a £1,000 central training budget over three years for each nurse, midwife and allied health professional, as well as increased funding for wider education and training budgets to NHS staff.<sup>29</sup>

In addition, on 7 July 2020, HEE announced £10 million to help support the growth of the clinical workforce and to expand the number of placements for people studying nursing, midwifery, and selected health professionals. An additional investment of £28 million was also announced on 21 September 2020 to support international nurses who are wanting to join the NHS front line.<sup>30</sup> This investment should help achieve the LTP goal of delivering an additional 50,000 nurses.<sup>31</sup>

Finally, HEE received £60m as part of the People Plan funding for 2020/21. Just under half has been allocated to mental health (£27.8m including Advanced Clinical Practitioners), showing the priority it is being given within the system.

The recently published People Plan for 2020/21 focuses on the national and local steps that need to be taken for the rest of the financial year. We were pleased to see HEE's continued investment in training the future mental health workforce to support significant expansion in psychological therapies for children and young people, boosting the number of advanced clinical practitioners, psychiatrists and mental health nurses. There is also a welcome focus on expanding shortage specialties; wellbeing and support for NHS staff; more flexible ways of working; equality, inclusion and diversity; return to practice initiatives; and international recruitment. However, a comprehensive NHS workforce strategy is needed for the longer-term, building on the available resource to be set out in the 2020 CSR.<sup>32</sup>

## **Recommendations**

1. At the 2020 CSR, the Government to commit to:
  - a. double the number of medical school places in England, at an estimated cumulative cost of £5.257bn by 2028/29 or £1.223bn per annum when fully implemented in current prices<sup>33</sup>, allocate those places to schools that have a clear plan to encourage more students to choose a shortage specialty, including psychiatry, which would equate to £420.54m of those total costs or £97.80m per annum when fully implemented in current prices if 8% of the total new places are taken by doctors choosing psychiatry
  - b. build on the current planned increases to the continuing professional development (CPD) budget for nurses (as announced at the Spending Round 2019) and work towards full

restoration of up to £300m per year. 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, and

- c. commit to a multi-year settlement for workforce training and education to allow for the growth in the mental health workforce, including via new roles, necessary to deliver the LTP and the recommendations of the Independent Review of the Mental Health Act.
2. As we move into the next phase of the COVID-19 pandemic, we are calling for urgent actions to be taken by the Government, including:
- a. continue to provide active national support to staff through a sustained and coordinated approach to mental health and wellbeing during the recovery period, and provide clear guidance to employers based on recommendations included in our Going for Growth plan
  - b. ensure that all mental health employers who need additional medical staff (consultant or junior level) have funding to employ the NHS staff considering a return to the NHS
  - c. encourage new ways of working and delivering care, based on the innovative methods used during the COVID-19 pandemic, which should also contribute to a better work-life balance
  - d. articulate what strong, diverse and compassionate leadership at all levels looks like and ensure it can be implemented for long-term benefit
  - e. ensure that all medical schools have plans in place to enhance medical students' exposure to and interest in psychiatry. Our Choose Psychiatry Guidance for medical schools provide helpful checklists for medical schools to develop their plans
  - f. commission adequate and appropriate foundation and specialty training posts to support the increased cohort of medical school graduates
  - g. work with the RCPsych to increase retention from Core to Higher Specialty Training and tackle attrition in psychiatry training
  - h. recruit more Physician Associates and other roles (such as Advanced Clinical Practitioners) in mental health and learning disability. Our members reported that having Physician Associates has been the one constant during the crisis and helped massively in maintaining safe patient care on the wards
  - i. ask all deaneries and mental health trusts to put in place a range of measures as set out in our Supported and Valued report
  - j. develop and implement measures to make psychiatry training and careers in the NHS more flexible and attractive by developing credentials and run-through pilots, such as those in Liaison Psychiatry and Child and Adolescent Psychiatry, and less than full time (LTFT) training
  - k. review appraisal and revalidation for retired doctors and tax penalties to prevent the loss of highly-skilled and experienced senior mental health professionals, as there is evidence that consultants are still retiring early despite recent changes to NHS pensions
  - l. 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 (BAME) groups at a disadvantage
  - m. ensure underfilled psychiatric specialties such as Old Age are on the shortage specialty list in their own right – particularly at higher specialty training, Specialty and Associate Specialist (SAS) and consultant level – based on the significant evidence that these specialties are in national shortage, and
  - n. fund a collaborative 'Mental Health Careers' recruitment campaign aimed at secondary school students, and possibly teachers and parents.
3. NHS organisations to urgently:

- a. take practical measures to improve the wellbeing of mental health staff, get the ‘basics’ right, ensure both staff and patient safety, increase retention and encourage those who have left the workforce to return to work
  - b. find practical ways of ensuring careers are attractive and rewarding, value staff for their contribution through opportunities for flexible working, improve workplace facilities which promote health and wellbeing, and give rewards and benefits
  - c. embed the health and wellbeing recommendations included in our Going for Growth plan following the first COVID-19 outbreak
  - d. continue to provide significant support for staff mental health and retention, through the implementation of the People Plan to 2020/21 and the recommendations of the NHS Staff and Learners' Mental Wellbeing Report (also known as the Pearson Review)<sup>34</sup>
  - e. carry out risk assessments for vulnerable staff, including those from BAME groups, as a priority and make appropriate arrangements, including the recommendations outlined in our associated Task and Finish Group<sup>35</sup>
  - f. increase the number of trust-supported academic activities and safeguard academic sessions, as an important tool for recruitment and retention
  - g. put in place a plan to retain returners in response to the COVID-19 pandemic
  - h. skill up the existing workforce to use digital therapies as effectively as possible, where appropriate
  - i. proactively engage with psychiatrists when they approach retirement and put in place suitable offers to retain them, including job shares, opportunities for special interest time, access to CPD and peer groups and adequate digital support, and
  - j. over the next decade, reverse the decline in academic psychiatry posts with a 50% increase in Clinical Senior Lecturer posts.
4. Once those urgent actions have been taken, HEE and NHSE/I to continue to work with the College and other key partners on the next steps for achieving a sustainable mental health workforce. We are currently developing a list of innovative workforce solutions so that we can support the mental health workforce to face existing and new challenges and we look forward to working with HEE and all relevant stakeholders on a dedicated plan to expand the psychiatric workforce beyond 2021.
  5. We have launched our workforce strategy from 2020 to 2023, seeking to ensure we have a highly skilled mental health workforce by increasing recruitment into psychiatry, improving retention and wellbeing in psychiatry, promoting psychiatric leadership, and recruiting and retaining Physician Associates and other roles in mental health.<sup>36</sup> We look forward to working with all relevant stakeholders to implement the actions included within our Strategy.

Further details relating to the workforce are included on pages 55-57.

#### **OBJECTIVE 4: Technology – digital transformation for mental health services**

Investment in technology can improve care, increase productivity and release staff time. The COVID-19 pandemic has dramatically increased the need to embed technology into healthcare provision, with remote working and consultations becoming increasingly widespread across mental health services. Mental health providers should use the COVID-19 pandemic as an opportunity to improve patient care (e.g. choice) and workforce (e.g. increased flexibility) through digital technology and remote working. The NHS has an opportunity to embed innovative practices that have been used during the pandemic and not to presume usual ways of working are most efficient.

Remote consultations 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. But it is

also important to acknowledge the significant risk of digital exclusion among patients, and how technology is not always accessible to all or designed with the users at its centre.

It is important that 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 are not disadvantaged.<sup>37</sup> Clinicians and managers must think about how to mitigate against widening inequalities with new technologies.

In order to maximise the benefits that using technology can bring, providers must have adequate equipment. When we asked our members to assess the IT equipment they had available to conduct their duties remotely during the COVID-19 pandemic, we found only 19.7% of members in England (257 of 1,303) felt they were 'fully equipped' with a further 38.3% (499) responding that they were 'well-equipped'. At the other end of the scale, 4.35% confirmed that their current IT equipment left them 'unequipped to conduct most/all duties' and 10.24% unequipped to conduct some duties.<sup>38</sup>

The Global Digital Exemplars (GDE) and Digital Aspirants programmes are supporting providers to deliver better care using improved digital technology and innovation. The programmes are showing promise, but combined they are currently only supporting 11 mental health trusts.<sup>39,40</sup> Advancing the use of technology in mental health services is also of critical importance with regards to Electronic Patient Records (EPRs). Currently, 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. Clinical interpretation of data not only has benefits for patients and the wider population but also enables clinicians to benchmark against their peers which helps to drive up quality.

The majority of Mental Health Act related activity is still carried out using paper-based systems, including forms for assessment, medication or leave. The Independent Review of the Mental Health Act found that digital enablers could provide patients with a modern and consistent way to access information about the Act, their rights, safeguards and treatment processes.<sup>41</sup>

## Recommendations

1. DHSC, NHSE/I and NHSX to invest £135m of capital funding to mental health trusts for IT infrastructure by 2024/25.
2. DHSC, NHSE/I and NHSX to expand the Digital Aspirant programme to a further 10 mental health trusts by 2024/25, underpinned by £65m of additional capital funding.<sup>42</sup> This should build on the learning from the Global Digital Exemplar programme.
3. DHSC, NHSE/I and NHSX to set up a new Mental Health Innovation Fund underpinned by £50m over four years.<sup>43</sup>
4. When working with systems to define 'what good looks like' for a digitised health and care system, NHSX to require systems and providers to set out clear plans for mental health technology and innovation. As part of this work, NHSE/I should ensure that service user feedback on the digital technology rolled out during the pandemic is collected and evaluated to inform its future use.
5. NHSX, NHSE/I and other public health services to ensure that people who are digitally excluded are still able to access mental health services and support. This should include ensuring clinical pathways are developed for those without access to remote/digital communications.
6. NHSX, NHSD and ICS Leads to work towards making IT systems interoperable between all health providers, primary and secondary care, and between themselves and providers of social care.
7. We support NHSX and NHSE/I's move to determine a minimum and optimal indicative benchmark level of technology revenue spend linked to digital maturity standards that are under development, what that level might be; and how trusts might move towards it over time.

8. DHSC and NHSE/I to work to ensure 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.
9. CQC to include in their assessments of NHS providers how appropriately they are using digital solutions.
10. NHSX and NHSE/I to ensure 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. It should 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.
11. HEE and NHSX to invest in training to raise the digital literacy of the NHS workforce.
12. NHSX 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.

We hope this briefing provides a useful steer to Government, DHSC, NHSE/I, other relevant departments and ALBs, and to NHS providers and commissioners ahead of the CSR in autumn 2020. We also hope it is useful for strategic and operational planning for the NHS and local authorities for 2020/21 and beyond, aligned to the mental health related commitments in the NHS Long Term Plan and the recommendations of the Independent Review of the Mental Health Act.<sup>44</sup>

We would be happy to provide further detail on any of the information contained within this paper. We recognise this is an iterative process and, as such, we might further refine our recommendations over the coming months as the COVID-19 pandemic progresses.

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<sup>16</sup> Dorset Healthcare is categorised as a mental health trust, but the seed funding was for 12 community hospitals.

<sup>17</sup> Decisions about which mental health trusts should be prioritised for seed funding for HIP projects should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads. Without wishing to presume the outcomes of those discussions, we have identified some trusts that might benefit from capital transformation funding in particular given the age of their estate or a poor CQC safety rating. These trusts include:

*Inadequate for Safety* (acute wards: working age adults and psychiatric intensive care)

1. Bradford District Care NHS Foundation Trust
2. Lancashire and South Cumbria NHS Foundation Trust
3. Leicestershire Partnership NHS Trust
4. Nottinghamshire Healthcare NHS Foundation Trust
5. Sheffield Health and Social Care NHS Foundation Trust

*Ageing estate* (NB - As of most recent data in 2015, in order of highest proportion of estate built before 1948)

6. South West London and St George's Mental Health NHS Trust
7. South London and Maudsley NHS Foundation Trust
8. West London NHS Trust
9. Surrey and Borders Partnership NHS Foundation Trust
10. Devon Partnership NHS Trust
11. Oxford Health NHS Foundation Trust
12. Kent and Medway NHS and Social Care Partnership Trust

<sup>18</sup> Ibid.

<sup>19</sup> This is on top of the Public Health Grant funding to expand drug and alcohol use disorder services.

<sup>20</sup> CQC and NHS Improvement now report and rate use of resources (UoR) for non-specialist acute trusts. These assessments are carried out by a team from NHS Improvement who provide their findings to CQC in order for CQC to write the assessment report and decide a trust's UoR rating for use of resources. This rating is then combined with CQC's existing five quality ratings for the trust.

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<sup>22</sup> The Public Health Grant can be used for both revenue and capital purposes -

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<sup>23</sup> The Public Health Grant can be used for both revenue and capital purposes -

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