10 Year Plan: RCPsych response

December 2024

Introduction

This response to the Government's 10 Year Plan for the NHS compliments the more detailed submission the Royal College of Psychiatrists made for the proposed cross-government mental health and wellbeing plan by the previous Government. That submission called on DHSC, other government departments, the NHS and its arm's length bodies, local government, and key partners to commit to ambitious and targeted action to help achieve universal coverage by 2030, as per the United Nations Sustainable Development agenda. This should be designed to: promote good health and wellbeing; prevent mental illness; intervene at the earliest opportunity; and ensure those who need it can access timely, high-quality treatment and support.

The College has also contributed to a joint Mental Health Policy Group (MHPG) response.

What do you want to see included in the 10 Year Plan and why?

It is essential to see a reaffirmed commitment to delivering parity of esteem between mental and physical health articulated through this plan, covering areas such as:

- **Delivery of the full suite of approved mental health waiting time standards to improve timely access to care in the community**, alongside the **necessary investment in service expansion to ensure standards are attainable and access to services becomes comparable to that for physical health services**. As the Darzi review highlighted, mental illness currently only receives around 10% of funding while being responsible for around 20% of the disease burden.[1]
- **Retention and recruitment of the mental health workforce, while also ensuring recurrent investment into staff mental health and wellbeing initiatives**. Medical and nursing vacancies remain considerably higher in mental health than acute services.
- **Investment in the mental health estate, across both inpatient and community services**, to address a growing maintenance backlog, ageing of estate and reduced therapeutic environment.
- **Improvements to patient flow and integration between primary and secondary care, harnessing digital technology** where appropriate.
- **Recognition of the role that mental health services and public mental health can play in boosting productivity** across the wider workforce and alleviating long-term sickness.

Without comprehensively addressing the core components of service delivery, the NHS will continue to face challenges in ensuring therapeutic care and patient safety.

Over the next 10 years, we want to see a marked improvement in the delivery of mental health services; supporting people earlier, ensuring prompter access to treatment and keeping more people well. None of which will be possible without a comprehensive look at patient safety; ensuring there is the workforce to deliver therapeutic treatment, within the context of reduced system pressures, in a modernised and safe environment.

Psychiatrists have key roles to play in prevention through facilitating timely access to services, supporting people with mental illness to obtain and remain in healthy working

conditions, and in helping employers understand the interface between mental health and occupational function. Investment in mental health services can help to boost wider workforce productivity, with estimates putting the cost of poor mental health to UK employers at around £51bn per annum.[2] Moreover it would alleviate the situation where 1.35 million people off work with long-term sickness report 'depression, bad nerves or anxiety' among their conditions.'[3]

Strategic alignment between the 10 Year Plan and the NHS Long Term Workforce Plan

For the implementation of the 10 Year Plan to be successful, there must be **strong strategic alignment with the NHS Long Term Workforce Plan**. We know the Workforce Plan is due its biennial refresh in 2025 and therefore emphasise the **importance of ensuring mental health and learning disabilities continues to receive sufficient attention**. This next iteration should moreover be supplemented with an implementation plan to support strategic linkages between the 10 Year Plan and Workforce Plan. The original version pulled no punches in underlining the workforce challenges in the sector and acknowledged workforce demand is at its highest for mental health and learning disabilities (4.4% annually).[4]

We welcome the Government's commitment to delivering the Workforce Plan and to expanding the specialist mental health workforce by 8,500 posts over this Parliament.

It is essential the requisite investment is delivered and sustained across training pathways to ensure the planned doubling of medical school places (costed at £1.85bn in 2021 prices by the York Health Economics Consortium[5]), 93% increase in mental health nursing training posts and 26% rise in training for clinical psychologists and child and adolescent psychotherapy by 2031/32 are implemented.

Retention and recruitment of sufficient numbers of skilled clinical staff to meet patient needs is recognised as the most significant delivery risk for the NHS Long Term Plan and wider efforts to ensure parity:

- Between 2016-2024 increases in specialist mental health workforce were substantially below targets in previous Government strategies. Only 275 consultant psychiatrists and 6,988 mental health nurses were added to the NHS workforce[6] compared to 1,040 and 12,300 posts respectively.[7]
- The 2023 RCPsych workforce census reported 15.9% of consultant psychiatrist posts and 20.4% of SAS psychiatrist posts were vacant in English NHS trusts. When factoring in locums, the 'true vacancy rates' were 29.1% and 31.6% respectively.[8]

The specialist clinical expertise that can only be provided by experienced psychiatrists is integral to effective mental health service delivery, plus secondary and tertiary prevention. Consultant psychiatrist capacity must be increased to enable more to assume medical leadership roles and undertake vital research.

Research and education must also be integral to training and workforce development for all staff across multi-disciplinary teams, with clinical practice and service development grounded in evidence and informed by academic psychiatry.

Academic psychiatrists undertake research and educational activities to improve our understanding and treatment of mental illness, with well-functioning clinical settings essential for delivering clinical academic work.

NHS staff wellbeing and retention

While government plans to expand the specialist mental health workforce is certainly welcome, this needs to be matched with efforts to ensure the retention of current clinical expertise.

NHS staff sickness figures reveal that 'anxiety, stress, depression, and other psychiatric illnesses' continue to be the most reported reason for sickness absence. In the twelve months up to and including June 2024, these conditions accounted for almost **6.9 million days or 26.3% of sickness absence**.[9]

Staff have reported high workloads, administrative pressures, working environments out of step with fundamental needs (e.g. lack of working tech and admin support), time-pressures and poor work-life balance. Many staff, including those from marginalised groups, have experienced burnout, and needed professional support for mental health and wellbeing.[10]

Research has estimated the financial cost to the NHS of poor wellbeing at £12.1 billion a year, and around £1 billion could be saved by successfully tackling this issue in the long term, through sustained, ring-fenced investment at scale.[11] The NHS Long Term Workforce Plan also acknowledged the retention benefits of providing staff mental health and wellbeing services, alleviating sickness absence and reducing locum need. It highlights University of East Anglia and RAND Europe findings, whereby 'investment of £80 per member of staff in mental health support can achieve net gains of £855 a year through savings from absenteeism and presenteeism.'[12]

NHS staff mental health and wellbeing provision has been substantially reduced since ring-fenced funding ceased, with 19 of 40 hubs having closed and a further eight facing closure as of May 2024.[13] The **College is therefore advocating for restoration of ring-fenced funding to reestablish the complete network**.

Care Under Pressure, an NIHR-funded research programme on workforce wellbeing, has provided key insights into how to further enhance wellbeing and support retention:

- Working environment improvements prioritised over wellbeing 'add-ons'
- Involving healthcare staff in developing wellbeing solutions that can address underlying problems
- Interventions designed with an emphasis on relationships and belonging, with wellbeing adversely impacted when staff feel isolated and unable to do their job.

Further Deloitte research illustrated that **employers attain an average return of £4.70 in productivity gains for every £1 invested in employee mental health and wellbeing**. Early intervention initiatives deliver even better ROI, at £6.30 for every £1 spent, with proactive interventions to support employees in the initial stages of mental illness (4.2:1) also more cost-effective than reactive (4.1:1).[14]

Delivering a modernised and sustainable mental health estate

A key aspect of patient safety relates to the quality of the estate. **Across mental health trusts, much of the estate remains unfit for purpose, posing serious challenges to those who receive treatment and who work in those facilities**. These challenges are not merely confined to health and safety, but also relate to the estate often being therapeutically poor and

adversely affecting workforce wellbeing, impacting productivity. Similarly, the way mental health care is provided in acute hospitals can put people at risk of poorer mental health outcomes.

The Covid-19 pandemic threw into sharp relief the need for urgent mental health estate capital investment. Lord Darzi's review also highlighted unacceptable conditions, drawing upon RCPsych research.[15]

The **current arrangements add unnecessary financial costs across the NHS such as longer acute length of stay and longer A&E waits, hampering overall service efficiency**. Sustained investment in mental health and learning disability estate across inpatient and community settings is integral to aiding recovery, improving patient flow and improving day-to-day experience of staff and patients, enhancing productivity of the former and enabling the latter to return to work sooner.

As part of its longer-term NHS ambitions, the **Government should commit ring-fenced capital funding for a Mental Health Infrastructure Plan**, encompassing the following:

- building and redevelopment programme
- improvements to inpatient therapeutic environments
- completing dormitory removal
- investment in community mental health facilities
- digital infrastructure.

This plan needs to have sustainability at its heart, for example supporting mental health trusts to eliminate use of fossil fuels.

Mental health estate investment is required for the Government to meet its parity commitments, but also to enable the NHS to become more sustainable and contribute to achieving net zero. **Mental health services should receive an equitable share of capital spending, with consideration given to the introduction of a mental health capital investment standard, similar to the existing revenue standard.**

What do you see as the biggest challenges and enablers to move more care from hospitals to communities?

Psychiatry provides an exemplar for effectively moving from hospital to community, with psychiatric beds declining sharply as community team capacity has increased.

Fully funded implementation of the clinical review of standards

Further efforts to increase community mental health services access can be driven by the **comprehensive introduction of the clinical review of standards**. These were approved in 2022, however have yet to be implemented and would require a step-change in resourcing services to be achieved. Proposed standards range from one hour for face-to-face assessment for patients of all-ages referred from A&E to four weeks from referral for community-based mental health services. Implementation delays are also having adverse consequences for other parts of the NHS resulting from the decline of patients' overall health, for example primary care capacity and physical illness monitoring.

Most specialist mental health services are currently excluded from waiting time measures – another barrier to achieving parity of esteem. We have only recently begun to benefit from

experimental mental health waiting lists data, which suggests around one in ten are waiting over two years.

Urgent and emergency care

The mental health urgent and emergency care pathway remains under substantial pressure. Mental health patients are more than twice as likely to wait more than 12 hours in A&E than all other patients combined.[16] Acute mental health length of stay has increased to more than 50 days, incurring additional costs and keeping patients out of employment longer, potentially jeopardising their return to the workplace. Increasing liaison mental health capacity would help to reduce overall A&E pressures, while also enabling more patients with mental health needs to more efficiently access the most appropriate support, including in the community.

A&E services need to be built to support people in mental health crisis, recognising those patients also have physical health needs. Among our proposed solutions are:

- Employ band 3-4 mental health staff as psychological support, improving patient experience and reducing the need for security guards without the need to train a new workforce.
- Rolling out a 'streaming service' akin to Humberside's best practice model – creating evidence-based safe and secure spaces for mental health A&E assessments

Inpatient service capacity

We know around one in ten adult acute mental health beds are currently occupied by someone clinically fit for discharge. Discharge plans at a system-level should be created on admission to hospital. Collaboration with supportive housing providers, community care providers and the VCSE can ensure a care pathway is in place.

As the NHS has made the move to focus on employment as part of treatment with employment advisors embedded, it must now do the same for housing. Meanwhile the number and cost of inappropriate out of area placements has been on the increase.

Local areas should be supported through national guidance to assess local bed capacity – deploying intelligent commissioning to ensure bed distribution matches local need and sharing of beds akin to provider collaboratives. These are not interventions which necessarily require funding, however without national encouragement areas are unlikely to know how to solve the issue.

Our members have nonetheless been clear they will need to continue to manage patients with highly complex needs in a high-quality inpatient setting. The College is offering to work with NHS England on an evaluation of the requisite number of mental health inpatient beds at various stages of community transformation, to ensure all-age population needs of those who still require inpatient care are met, including maximising the value of NHS resources.

Role of primary care

The interface between primary and secondary care needs to be reimagined to fully realise the community vision. There are some examples of psychiatrists working effectively with mental health practitioners within primary care, for example in Manchester and Southwark, however putting this on a more widespread and well-resourced footing would be welcome to support more integrated care pathways.

We can provide more details about a proposed pilot scheme for psychiatrists to be placed in GP practices.

Supporting older adults in the community

The starting point for older people who need mental, physical healthcare or both should be home based treatment, with psychiatric home treatment teams as the standard treatment approach across England. This could provide the model for a similar physical health response and mirrored in outpatient services to enable collaborative working. Services should be proactively designed to accommodate emerging new treatments, particularly for conditions such as dementia, supported by digital technology.

Psychological therapies for severe mental illness

An important enabler is to further improve access to evidence-based care for adults and older adults with severe mental illness (including people with eating disorders, mental health rehabilitation needs and a personality disorder diagnosis) to help people get better and stay well. This should include wider availability of psychological therapies for people with psychosis, bipolar disorder, and complex mental health difficulties associated with a diagnosis of a personality disorder.

Provision of such support in the community would help to **reduce inpatient admissions altogether or ensure patients are admitted for less time** before recovery, while also **facilitating further employment rate improvements.** Building further upon the progress made to increase availability of support to this important population is critical. We know other community-based interventions for this patient group, such as physical health checks, can reduce A&E attendances by 20% and mental health admissions by 25%.[17]

What do you see as the biggest challenges and enablers to making better use of technology in health and care?

Our members fully acknowledge the benefits that technology can bring to the delivery of mental health services and productivity improvements. They have also however been clear that a 10 Year Plan must also acknowledge the starting point faced by NHS staff and ensure **investment is also made urgently into bringing day-to-day IT infrastructure up to an efficient and effective standard** before more ambitious programmes are attempted.

Investment that enables technology across mental health services to be on a par with those in physical health must be matched by equal focus on governance and quality assurance around potential digital solutions. Digital transformation must moreover be clinically-led and designed with the end-users fully in mind, empowering NHS staff to take ownership.

Research increasingly shows how selective and targeted use of technology can have a meaningful impact on care quality and the role users can take in the organisation and delivery of services, for example by taking more control over their care, especially in the context of chronic illness.

The treatment of mental illness, far from being an area where digital is more difficult to use, has already shown itself to be in many ways a trailblazer. **Digital literacy throughout the medical career path is a key enabler for driving use of technology and to that the end the**

College has developed a Digital Literacy Framework.[18] The framework is based around these themes: increasing clinician efficiency and patient safety; improving patient outcomes and experience; and enabling digital mental health services for patients. It provides digital data literacy standards and is intended to facilitate all College members to have at least a core grounding.

Alongside this foundational learning, there is a clear need for a step-change in digital service provision within mental health care. To date, there has been **insufficient integration between digital and traditional care pathways which has adverse consequences for patient flow. Digital 'entry and exit doors' for patients could support delivery of the most effective intervention after referral and enable safe, effective discharge when treatment concludes.**

There is no conflict between the use of digital and patient voice - in fact where it is delivered effectively both are enhanced. That is why we welcome initiatives such as the principles recently published by NHSE which highlight how we can see an acceleration of the use of digital where it is adopted in a way that include commitments to:

- transparent consent models,
- guard against inappropriate use
- clinical benefits always being its driver, never being used to replace needed face-to-face care because of lack of staff.

We have seen examples where these principles have not necessarily been adopted and the impact has been to both affect the ability of that initiative and longer-term confidence in digital and technology-based models in the treatment and care of those with mental illness.

We would support effective ways of patients accessing their records, ideally through a single portal such as the NHS app. **Technology should be used to maximise efficiency**, for example ensuring optimised clinic slots and facility modelling. This, and other research endeavours, would be enabled by the **availability of anonymised patient data**, as provided by systems such as CRIS, CRATE and 'open safely'. Such approaches could be applied to all routinely collected patient data and used to optimise risk prediction, diagnosis, prognosis and treatment.

AI tools can play a transformative role in enhancing productivity through enabling a reduction in the administrative burden for clinicians and ensuring more time can be devoted to assessment and treatment. One striking example is that as currently implemented, autism assessments take 13 hours to complete, the majority of which is occupied by paperwork. While not replacing the integral role of clinicians, digital tools can be a key element of care provision alongside that expertise.

On a fundamental level, technology develops at such a pace and scale that this element of the 10 Year Plan will need to be kept under regular review to ensure the NHS can take advantage of the most appropriate opportunities available to it throughout the decade. This way the plan can reflect the quality of what is required to transform services, not just the speed within which it should be implemented.

What do you see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill-health?

Co-morbidities in physical and mental health

It is essential to raise awareness of the impact of poor mental health on physical health and vice versa. **Previous estimates have suggested that around 30% of people with a long-term physical health condition also have a mental health problem or 46% of people with mental health problems also have long-term physical conditions, equating to around 4.6 million**.

All three of the policy shifts envisioned in the 10 Year Plan need to keep this situation fully in mind to ensure the associated impacts on mental and physical health are acknowledged and responded to as early as possible.

Premature mortality among people with Severe Mental Illness (SMI)

It is well known that **people living with SMI suffer from premature mortality of 15-20 years on average compared to the general population** and a greater likelihood of developing preventable physical illnesses. While there has been **success in increasing the number of people presenting for annual physical health checks, there is more primary care could do** to ensure people attend these appointments, predominantly outreach to encourage those who currently aren't attending to access support and ensuring public health campaigns support the additional needs this cohort might have.

Broadening out the scope of the physical health check programme could also have a transformative impact on early intervention for preventable physical conditions across mental health for a wider group of patients. Our College Presidential Lead for Physical Health has commenced a project and we will share the findings in due course.

The importance of children and young people's services

Half of all mental illness arises before the age of 14 and we know how fundamental the early years are for laying appropriate foundations. Currently only a minority of under-5s with a mental health condition receive any intervention, with negligible coverage to prevent such conditions or promote mental wellbeing and resilience.

The College published a report on the case for action on Infant and Early Childhood Mental Health, which **makes recommendations to sustainably address the public mental health implementation gap for under 5s and their families**.

Alongside this, there is an undeniable case for **sustained and robust investment in the broad spectrum of services that support children and young people with mental health needs** across NHS and local authorities (including but not limited to children's social care, health visitors and parental/carers support).

Children and young people should be treated as close to home as possible. We are **still coming to terms with the Covid-19 pandemic impact and urge future pandemic preparedness to be an integral element of the plan** to ensure lessons are learned.

DHSC and NHSE must ensure join-up in the system between Mental Health Support Teams and Youth Futures Hubs, so they are built in parallel, not as siloed systems. It is **imperative the hubs have a mental health focus and young people are not deterred from accessing mental health support**. There also needs to be dedicated long-term investment in early intervention provision in local communities, alongside later intervention, crisis and urgent care. **Psychiatric capacity must also be built into the framework of each**, ensuring those who need more clinical support can easily access it.

Inequalities and social determinants of health

Health is significantly influenced by the social, economic, and environmental conditions around us. In the UK, people living in the poorest areas die earlier than those in richer areas. All risk factors for premature mortality – smoking, poor diet, and harmful alcohol use – are impacted by these socioeconomic factors.

The 10-year Plan must take account of the vulnerabilities of those facing inequalities, recognising how often they are the least likely to access treatment. Lord Darzi's review rightly highlighted the links between poverty and homelessness, among other determinants and poor mental health. **Stigma and a lack of digital access also act as barriers to care**. It must also **consider how some ethnic groups are more likely to be sectioned than others** and while reforms to the Mental Health Act are welcomed, there are non-legislative choices which would improve care.

Tackling determinants of mental ill-health is not entirely within the NHS' control and therefore there remains the need for a cross-government focus on tackling the determinants of poor mental health, which requires a whole society approach.

Trauma-informed care

There is good evidence that a more holistic approach, which values the development of trusting therapeutic relationships that consider how and why a person came to need support, is better for both patients and staff. Working with those with lived experience, trauma-informed and culturally competent services should be integral, however the NHS is yet to embed this.

Trauma-informed (TI) principles must apply to all aspects of the system, with change and learning coming from the top and then applied across leadership, workforce initiatives, the built environment and the therapeutic offer. This can be **implemented through a national strategy and funding commitment**, to deliver effective, consistent TI care and enable evaluation. Alongside increased provision of trauma-informed mental health services, this would need to be supported effectively by national bodies.

Raising awareness of the risk factors for dementia

We would welcome the chance to work with Government to develop a **public health campaign aimed at tackling the risk factors for dementia** (hearing loss, hypertension, smoking, obesity, depression, physical inactivity, diabetes, excessive alcohol consumption, traumatic brain injury, air pollution, social isolation, poor vision and high cholesterol). This could also have benefits for other conditions, for example cardiovascular disease.

Substance misuse

There are **substantial levels of co-occurring mental illness and substance use disorders**. In 2022/23 74.8% of people entering drug treatment and 83.7% of people entering alcohol treatment were also identified as having a mental health treatment need.[19]

The **transfer of substance use disorder services into local authorities has greatly contributed to fragmentation** between the treatment of mental illness and substance

misuse, while also seeing the latter suffer from substantial real-terms spending cuts. While this spending gap has narrowed since the independent Dame Carol Black review, it remains a clear service capacity impediment.

This fragmentation has resulted in adverse consequences such as: **recruitment and retention of addiction psychiatrists in a climate of uncertainty around sustainable resourcing arrangements**; **lack of capital funding**; and a **contracting** model that drives down the price paid by providers.

Addressing the treatment gap for eating disorders

The 2019 Health Survey for England reported 4% of adults experience significant impairment due to eating disorders.[20] Lifetime adult prevalence has been estimated at 6%.[21] This was exacerbated by the Covid-19 pandemic and 2023 data showed positive screening among 17-19 year olds was 12.5% for eating disorders and 59.4% for possible eating problems.[22]

Untreated, eating disorders pose a substantial risk, leading to severe mental and physical health consequences, reduced quality of life, and reduced social and economic participation. However, **in 2022, only 3.6% of children and young people and 1.3% of adults with eating disorders in England were referred to and accepted by specialised services**, with just 2.4% of children and young people receiving specialist treatment. **Preventive interventions remain largely unavailable, despite evidence-based psychological models.**

Closing this gap requires coordinated action, with a focus on ensuring proportional coverage for both the general population and high-risk groups. A **national eating disorders strategy**, which could **introduce a stepped care model where capacity and capability in treatment and prevention is significantly enhanced, is achievable within the 10 Year Plan**.

Please share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in.

Immediate term

- **Recurrent investment in NHS staff mental health and wellbeing initiatives**
- **Reaffirmed commitment to the Mental Health Investment Standard** and consideration given to **introduction of a capital investment standard (including digital technology)** to ensure a fair share for mental health.
- **System-level discharge planning to be supported through specific and targeted funding of £100m per annum** for mental health-related discharge packages.
- **Ongoing commitment to implement the Advancing Mental Health Equalities strategy** and **retention of the Patient and Carer Race Equality Framework**, with sufficient resources to address mental health service inequities in access, experience, and outcomes.
- **Investment into day-to-day IT infrastructure** to bring this up to an effective standard.

Medium-term

- Delivery of **approved mental health waiting time standards, alongside necessary investment in services**.

- **Investment across full training pathways to ensure planned increases in staffing through the NHS Long Term Workforce Plan are implemented**.
- The Government should commit **ring-fenced capital funding for a Mental Health Infrastructure Plan**.
- **Roll out Mental Health Impact Assessment Tool** across all government departments and by end of the Parliament to local government and ICSs.
- **Improved mental health data flow –** ensuring more comprehensive, up-to-date and reliable datasets. Future NHS datasets should be made publicly available and current weaknesses in collection outside of the NHS should be addressed.
- **A&E services built to support people in mental health crisis**. Employ band 3-4 mental health staff as psychological support and roll out 'streaming service' akin to Humberside.
- **Consideration given to appointing Housing Directors in each trust to improve discharge processes**, akin to Southern Health NHS FT.
- Recommendations from the College's Early Years report: the **need for agreement on the level of population coverage**; **sufficient resources to facilitate that coverage and deliver the trained workforce**; a **national workforce strategy**; and **co-produced services with those with lived experience**.
- **Payment for outcomes introduced**, drawing upon the College's outcomes report. All mental health services should have a patient-reported outcome measure.
- **Further investment is needed to facilitate appropriate follow-up support once physical health checks have been completed**, for example embedding physical health liaison in mental health services.
- **Rationalisation of key performance indicators** to shift focus more to care quality, requirements agreed with clinicians.
- National eating disorders strategy, focusing on **all stages of effective disease management underpinned by evidence-based guidelines** including: prevention (**targeted at high-risk groups**); early identification; primary care and intermediate services providing an initial response; specialist care; structured workforce development; and ongoing research and evaluation.
- DHSC to **introduce public policies that restrict alcohol availability and/or raise alcohol taxes to discourage consumption**.
- **ICBs should be given responsibility for alcohol care teams and alcohol outreach services**.
- **Commissioning arrangements for substance misuse services overhauled, with joint NHS-LA commissioning an essential first step forward**.
- Integration of **nature-based solutions to prevention and treatment of mental health conditions**, drawing upon evidence.[23]
- **National strategy and funding commitment for trauma-informed care**.
- Ensuring **Mental Health Support Teams and Youth Futures Hubs are established in parallel** and not siloed systems.
- Wider availability of **psychological therapies for people with SMI**.
- **Public health campaign aimed at addressing dementia risk factors**.
- **Pilot scheme to place psychiatrists within GP practices** to assess patients with needs beyond GP expertise.

Longer-term

- **Complete the requisite steps to ensure full parity of esteem between mental and physical health**, as defined by DHSC and NHSE.

- **Ambition to ensure every child has timely access to the appropriate assessment(s) for their needs**.
- **Transition from CYP to adult mental health services to mirror those in place for paediatrics**. Regardless of age, removing this artificial barrier should be an ambition.

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