

# **The Royal College of Psychiatrists’ Spending Review Representation Autumn 2021**

## 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.

## About this submission

This submission lays out the Royal College of Psychiatrists' key recommendations for aspects of mental health provision needing both capital spending and additional revenue spending for the three years 2022/3 – 2024/5, on the understanding that the Treasury is planning a three-year settlement. This includes the Department of Health and Social Care's (DHSC) total departmental expenditure limits (TDEL) covering capital spending (CDEL), in relation to infrastructure, services, people and technology. Overall revenue spend (RDEL) was announced in September 2021, though remains partly unallocated. As such, our submission includes revenue related funding asks.

We note that the three-year spending review settlement goes beyond the current Long Term Plan, which only covers the period to March 2024. While we have included provisional figures for 2024/25 we urge that a plan for the subsequent phase of mental health service improvement - and a funding settlement to match - is forthcoming within the next two years.

Given that health and social care are devolved areas of administration and spending, our submission focuses on making the case for a good mental health settlement in England, on the understanding that the Barnett Formula will see Northern Ireland, Scotland, and Wales' health and social care settlements set accordingly. We highlight what system action is needed by key players, including government, NHS bodies (England), and local authorities (England), and what underpinning funding they need to implement this action. While we acknowledge that there has been greater than ever funding going to mental health in recent years, our recommendations also reflect historical underfunding and higher than ever levels of need following the COVID-19 pandemic. As such, we make the case for significant additional investment through this settlement. Our asks are evidence-based and incorporate intelligence from our thousands of members working across the country to improve the nation's mental health.

Whilst we acknowledge that issues surrounding housing, benefits, employment, education and the justice system, for example, are inherently linked to people's mental and physical health and need to be properly resourced, we generally do not attempt to cover the funding commitments of other government departments (with exception of the relevant mental health services provided by the Department for Levelling Up, Housing and Communities – formerly the Ministry for Housing, Communities and Local Government).

However, as members of the Mental Health Policy Group – an informal coalition of six national organisations working together to improve mental health, comprised of the Centre for Mental Health, Mental Health Foundation, NHS Confederation Mental Health Network, Mind, Rethink Mental Illness and the Royal College of Psychiatrists – we have included some wider shared asks within this submission. We would be happy to provide further detail on any of the information contained within this paper.

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## Summary of costings

The proposed mental health capital investment programme covers the following:

- Health Infrastructure Plan (HIP) for Mental Health – major building and redevelopment projects, improvements to inpatient therapeutic environment, supporting delivery of the Long Term Plan and Mental Health Act Review through investment in community and crisis services enabling implementation of the Dame Carol Black Review and investment in technology, research and development.
- Backlog maintenance costs across mental health and learning disability sites.

This proposed investment is in addition to day-to-day capital spending for NHS mental health trusts. For example, in 2019/20, mental health trusts spent £335m on equipment, maintaining their existing estate, and ongoing backlog maintenance issues.<sup>1</sup>

***Table 1. Mental health capital investment programme – investable propositions for 2022/23-2024/25 and beyond***

MENTAL HEALTH CAPITAL INVESTMENT PROGRAMME	PROJECT	TYPE OF CAPITAL INVESTMENT	COST (£BN)	INVESTMENT PERIOD	SOCIETAL BENEFITS	ECONOMIC BENEFITS
<b>Health Infrastructure Plan (HIP) for Mental Health – to include longer-term assets that support the NHS’ delivery of world-class mental healthcare and the accompanying healthcare</b>	12 new major building and redevelopment projects for mental health facilities to support modernisation of the estate and begin to alleviate inpatient care gaps and to enhance the therapeutic environment	Public capital/ CDEL, private capital, fully serviced occupancy	£1BN, of which: <ul style="list-style-type: none"> <li>▪ £0.535 is committed by 2024/25</li> <li>▪ £0.465 by 2030 (inclusive of £30m seed funding)</li> </ul>	<ul style="list-style-type: none"> <li>▪ 6 hospitals/ schemes to be delivered by 2024/25</li> <li>▪ 6 hospitals/ schemes to be delivered by 2030</li> </ul>	<p>Improved therapeutic environment with more open space, improved access to outside gardens and safe places for family/friends/ carers to meet will support recovery</p> <p>Ability to deliver joined up care in communities with</p>	<p>Increased staff productivity</p> <p>Reduced agency staff costs</p> <p>Reduced turnover of staff</p> <p>Fewer inappropriate out of area</p>

<b>infrastructure that supports mental health outcomes (Actions 1-6 Objectives 1 and 2)</b>					<p>NHS, council and voluntary and community organisations</p> <p>Reducing out of area placements, meaning patients can stay closer to home and their friends and family</p> <p>Improved staff health and wellbeing and improved staff satisfaction</p> <p>Increased morale and retention of staff</p> <p>Improved environmental impact and sustainability</p>	placement bed days
	<p>Improve the therapeutic environment of mental health and learning disability/autism inpatient settings by beginning to:</p> <ul style="list-style-type: none"> <li>eliminate mixed sex accommodation</li> <li>procure en-suite facilities for existing single rooms</li> </ul>	Public capital/CDEL	~£0.750	2022/23 to 2024/25	<p>Enhanced privacy and dignity</p> <p>Improved patient experience and outcomes</p> <p>Improved equity of access</p> <p>Improved accessibility for patients with disabilities</p>	<p>Reduced length of stay</p> <p>Reduction in readmission rate</p>

	<ul style="list-style-type: none"> <li>▪ minimise the risks of harm through innovative safety improvement projects, and</li> <li>▪ make the estate more suitable for people with disabilities.</li> </ul>					
	Complete the elimination of dormitory provision and replacing with single en-suite rooms by reaffirming investment in this programme	Public capital/ CDEL	£0.300 <ul style="list-style-type: none"> <li>▪ Building on the investment already delivered in 2020/21 and 2021/22</li> </ul>	2022/23 to 2023/24	Enhanced privacy and dignity  Improved patient experience  Improved patient outcomes	Reduced length of stay  Reduction in readmissions
	New building and redevelopment schemes for community mental health facilities including clinical and office space and essential digital infrastructure	Public capital/ CDEL, private capital, fully serviced occupancy	~£0.700	2022/23 to 2024/25 <ul style="list-style-type: none"> <li>▪ £500 up to and including 2023/24 to align with LTP expansion programme</li> <li>▪ £200 is assumed for 2024/25 for ongoing expansion.</li> </ul>	Well-procured clinical space in the community improves both the quality and quantity of community-based treatment on offer  Sufficient space for health professionals to assess and treat patients  Patients not having to travel far away from their home  Improved patient choice and outcomes, including helping to address inequalities of	Widened access to services provides more people with support and helps to reduce economic cost of mental illness  Improved staff productivity  Fewer missed appointments  Increase in staff retention



					access caused by issues such as providing a suitable environment for patients who are also carers of children to attend with them (disproportionately women)	Reduction in inequalities of access
	<p>New building and redevelopment schemes for crisis mental health facilities, including:</p> <ul style="list-style-type: none"> <li>alternative forms of age-appropriate provision for those in crisis or requiring a mental health inpatient admission e.g. health-based places of safety, sanctuaries, safe havens, crisis cafes and crisis houses</li> <li>age-appropriate assessment spaces in A&amp;E and acute hospitals for people with mental health/learning disability needs, and</li> <li>new mental health ambulances/ transport vehicles to reduce inappropriate ambulance or police conveyance to A&amp;E.</li> </ul>	Public capital/ CDEL, private capital, fully serviced occupancy	<p>~£0.270, of which:</p> <ul style="list-style-type: none"> <li>~£0.180 for crisis alternatives <sup>2</sup></li> <li>~£0.080 for A&amp;E/acute mental health spaces <sup>3</sup></li> <li>~£0.010 for mental health ambulances /transport vehicles <sup>4</sup></li> </ul>	2022/23 to 2024/25	<p>Improved patient outcomes</p> <p>Better patient experience</p> <p>Reduced use of A&amp;E</p> <p>Reduced hospital admissions</p>	<p>Reduced use of A&amp;E</p> <p>Reduced hospital admissions</p>

	Capital funding for drug and alcohol use disorder services <sup>5</sup>	Public capital/ CDEL, private capital	~£0.090	2022/23 to 2024/25	<p>Improved quality and availability of drug and alcohol use disorder services</p> <p>Improved therapeutic environment</p> <p>Ability to deliver joined up care in communities with NHS, council and voluntary and community organisations</p> <p>Improved staff health and wellbeing and improved staff satisfaction</p> <p>Increased morale and retention of staff</p>	<p>Reduced A&amp;E presentations</p> <p>Reduced substance use associated crime through better outcomes</p> <p>Increased participation in the workforce through stabilisation and recovery</p>
	<p>Research &amp; Development in Mental Health and Dementia, including:</p> <ul style="list-style-type: none"> <li>the prevention agenda</li> <li>the impact of trauma arising from the COVID-19 pandemic</li> <li>the mental health impact of long COVID</li> <li>research to improve the productivity and</li> </ul>	Public capital/ CDEL	▪ ~£0.120 <sup>6</sup>	2022/23 to 2024/25	<p>Improved research facilities and support services</p> <p>Encouraging innovation and research into mental health, learning disabilities, autism and dementia</p>	<p>Further preventative interventions identified</p> <p>More effective and efficient treatments identified</p>

	effectiveness of the NHS, and <ul style="list-style-type: none"> <li>the translation of basic science and support for the life sciences industry.</li> </ul>				Support for clinical academics in psychiatry	
<b>Backlog maintenance (Action 5)</b>	Eradicate high and significant risk backlog maintenance	Public capital/ CDEL	Combined high, significant and moderate: £0.203949 <ul style="list-style-type: none"> <li>High risk: £0.016171</li> <li>Significant risk: £0.075889</li> <li>Moderate risk: £0.111889 <sup>7</sup></li> </ul>	2022/23 to 2024/25 <ul style="list-style-type: none"> <li>addressing high risk in 2022/23</li> <li>significant risk between 2022/23 and 2023/24, and</li> <li>the current moderate risk by 2024/25.</li> </ul>	Patient and staff safety  Improved CQC ratings for safety  Improved staff morale and retention  Enhanced privacy and dignity  Improved patient experience and outcomes  Improved equity of access	Reduced agency costs  Reduction in liability costs  Reduced length of stay  Reduction in readmission rate
<b>Mental Health Innovation Fund (Action 7)</b>	Developing a new Mental Health Innovation Fund.	Public capital/ CDEL, private capital	<ul style="list-style-type: none"> <li>£0.036</li> </ul>	<ul style="list-style-type: none"> <li>2022/23 to 2024/25</li> </ul>	Improved patient choice  Improved patient outcomes  Improved staff satisfaction	Improved staff productivity  Fewer missed appointments  Increase in staff retention
<b>TOTAL</b>	<div>£3.470bn</div> <div>Investment by 2024/25: £3.005bn</div>					

**on top of day-to-day capital spending of an estimated £1,005m (based on 2019/20 figures), totalling £4.010bn**

**Investment to support ongoing HIP schemes up to 2030: £0.465bn**

**Table 2. Mental health services revenue investment – to support COVID-19 recovery and additional resource to ensure Long Term Plan delivery**

MENTAL HEALTH REVENUE INVESTMENT	PRIORITIES	COST (£BN)	SERVICE AND SOCIETAL BENEFITS
2022/23	<p>Restoration of services to trajectories outlined in NHSE Mental Health Implementation Plan<sup>8</sup></p> <p>Responding to demand for mental health services arising from COVID-19 pandemic</p> <p>Supporting the introduction of waiting time standards</p>	£1 BN TOTAL	
		£0.250	Retained funding for discharge support to ensure those who can be safely discharged into alternative services can do so, more therapeutic inpatient care and delivery of Mental Health Act (MHA) reforms
		£0.200	Driving ongoing expansion of CYP services, including Mental Health Support Teams (MHSTs)
		£0.200	IAPT expansion and restoration of LTP trajectory
		£0.200	Community Mental Health Team (CMHT) expansion, integration with primary care and waiting time pilots
		£0.100	Investment in other services including crisis lines, mother and baby units, adult eating disorders, dementia care
		£0.050	NHS Staff Support service retained
2023/24		£1.5BN TOTAL	

	Restoration of services to trajectories outlined in NHSE Mental Health Implementation Plan	<p>£0.300</p> <p>£0.250</p> <p>£0.300</p> <p>£0.400</p> <p>£0.200</p> <p>£0.050</p>	Retained funding for discharge support to ensure those who can be safely discharged into alternative services can do so, more therapeutic inpatient care and delivery of MHA reforms
	Responding to demand for mental health services arising from COVID-19 pandemic		Driving ongoing expansion of CYP services, including MHSTs
	Supporting the introduction of waiting time standards		IAPT expansion and restoration of LTP trajectory
			CMHT expansion, integration with primary care and waiting time pilots
			Investment in other services including crisis lines, mother and baby units, adult eating disorders, dementia care
			NHS Staff Support service retained
<b>2024/25</b>	Restoration of services to trajectories outlined in NHSE Mental Health Implementation Plan	£2.4 BN TOTAL	
	Responding to demand for mental health services arising from COVID-19 pandemic	<p>£0.300</p> <p>£0.450</p>	Retained funding for discharge support to ensure those who can be safely discharged into alternative services can do so, more therapeutic inpatient care and delivery of MHA reforms
	Supporting the introduction of waiting time standards		Driving ongoing expansion of CYP services, including MHSTs
	Maintaining progress beyond initial Long Term Plan by continuing to address care gap	£0.550	IAPT expansion and restoration of LTP trajectory

		£0.800	CMHT expansion, integration with primary care and waiting time pilots
		£0.250	Investment in other services including crisis lines, mother and baby units, adult eating disorders, dementia care
		£0.050	NHS Staff Support service retained

**Table 3. Other mental health-related revenue investment between 2022/23 and 2024/25**

MENTAL HEALTH-RELATED INVESTMENT	PRIORITIES	COST (£BN)	SERVICE AND SOCIETAL BENEFITS
<b>2022/23</b>	Public mental health securing growing share of public health spending	£0.0235	Improved prevention offer at local authority level
	Substance misuse service investment in line with Dame Carol Black review recommendations <sup>9</sup>	£0.119	Reduced substance use associated crime through better outcomes Reduced A&E presentations
			Improved employment prospects
	Medical school places growth (1,000 extra places compared to 2021/22)	£0.134	Progress towards sustainable supply of medical staff Greater capacity in the mental health system
	Early support hubs rollout	£0.103	Around 500,000 children and young people supported each year across all upper-tier local authority areas
<b>2023/24</b>	Public mental health securing growing share of public health spending	£0.047	Improved prevention offer at local authority level
	Substance misuse service investment in line with Dame Carol Black review's recommendations	£0.231	Reduced substance use associated crime through better outcomes Reduced A&E presentations
			Improved employment prospects

	Medical school places growth (2,000 extra places compared to 2021/22)	£0.267	Progress towards sustainable supply of medical staff Greater capacity in the mental health system
	Early support hubs rollout	£0.103	Around 500,000 children and young people supported each year across all upper-tier local authority areas
<b>2024/25</b>	Public mental health securing growing share of public health spending	£0.0705	Improved prevention offer at local authority level
	Substance misuse service investment in line with Dame Carol Black review's recommendations	£0.396	Reduced substance use associated crime through better outcomes Reduced A&E presentations Improved employment prospects
	Medical school places (3,000 extra places compared to 2021/22)	£0.401	Progress towards sustainable supply of medical staff Greater capacity in the mental health system
	Early support hubs rollout	£0.103	Around 500,000 children and young people supported each year across all upper-tier local authority areas



## Introduction

Mental health was long an area of under-investment. Despite it still leaving some way to go in terms of achieving parity of esteem with physical health, the fully costed Five Year Forward View (FYFV) for Mental Health plan, followed by the 2019 NHS Long Term Plan commitment that mental health services would grow faster than the overall NHS budget, has laid the foundations for transformative change. The ring-fenced increase in investment was forecast to be worth at least £2.3bn a year in real terms by 2023/24 compared to 2018/19.<sup>10</sup> Total CCG investment in 2020/2021 into mental health services was £12.10bn (including learning disabilities and dementia) compared to £10.56bn two years earlier.<sup>11</sup>

The increased investment had resulted in some significant advances, prior to the pandemic. For example, access to perinatal services had more than doubled since the FYFV baseline and the FYFV ambition of ensuring 35% of children and young people with a mental health condition were able to access treatment was met ahead of schedule.

Following the onset and first wave of the pandemic – with its widely recognised damaging consequences for the nation’s mental health – the 2020 Spending Review committed an additional £3bn to support the NHS’s recovery from the impact of COVID-19, including £500m COVID-19 Mental Health Recovery Plan funding to address waiting times for mental health services, give more people the mental health support they need, and invest in the NHS workforce. Specific areas within these themes that were funded as part of the Plan<sup>12</sup> included: discharge support, children and young people’s (CYP) services (including Mental Health Support Teams), adult community mental health services, Improving Access to Psychological Therapies service (IAPT) and 24/7 crisis lines.

Owing to both COVID-19 related service dislocation, and to the extra funding mental health has consequently received, a few positive innovations have been expedited. This includes the establishment of 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 where appropriate, and the expansion of CYP eating disorder services.<sup>13</sup>

However, despite these positive developments, the broader picture is of mental health services struggling to meet demand, despite the emergency cash injection. This is due to significantly increased numbers of people being referred to mental health services, over and above pre-pandemic levels of demand. During the peak of the pandemic 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, particularly via A&E, primary care and in child and adolescent mental health services. In parallel, many of the protective factors that are known to support good mental health such as social support and employment/education were effectively removed for many. Consequently, population mental health needs have increased significantly and there is currently little sign of this abating.

Meanwhile, the programme of work underway to improve and transform mental health services in England continues, with the implementation of the community mental health framework for adults and older adults, the Clinical Review of Standards expected to bring in waiting time standards across both emergency and community-based mental health services, and the proposed Mental Health Act reform expected to lead to significant changes to improve the process surrounding mental health detention. Such ongoing reforms of mental health services are essential towards achieving parity of esteem, and ensuring that those accessing them get the mental health support they need and deserve.

The ambitious but essential agenda outlined above must be underpinned by a fully funded, multi-year workforce settlement and strategy. We make the case for the number of medical school places and core psychiatry posts to be increased to ensure a sustainable supply of doctors. This is essential for services to reach the necessary capacity to deliver the Long Term Plan and further initiatives beyond 2024, including reform of the Mental Health Act. The workforce settlement must also offer sufficient investment in postgraduate education and training, with the future workforce requiring a robust grounding in prevention as well as intervention.

Also essential to parity is the upgrading of the estate which houses mental health services. The pandemic served to further highlight the already established inadequacy of the ageing estate, with a far greater proportion of people contracting COVID-19 in acute mental health settings than in standard acute trusts, compounding safety concerns. The need for improved facilities across inpatient and community mental health services is underscored both by the numbers of people needing to access these facilities, and by the obvious lack of investment to date, with mental health facilities losing out against others in the recent Health Infrastructure Plan (HIP) round.

Against this context, this submission makes the case for further investment in mental health. Mental health services need to be underpinned by investment in evidence-based best practice, research and investment in workforce education and training, as well as local government funding for public mental health, drug and alcohol use disorder services, and mental health social care support. Ring-fenced capital investment of £3bn, plus £1bn for day-to-day capital budgets, is needed across the mental health estate over the next three years to address the maintenance backlog, meet safety and accessibility concerns (for staff as well as patients), improve therapeutic environments, maintain privacy and dignity, meet sustainability exigences, and to ensure people's mental health needs are met in the most appropriate way.

Ultimately, the evidence contained within this submission is intended to ensure that mental health is not overlooked, and that no assumptions are made that mental health has had sufficient funding already. Given the egregiously low historical baselines there is still far to go before mental health services reach parity with physical health services. So, we urge the Government not to row back on their commitment to mental health in this critical time period. Now is the time to invest further, to embed previous progress, tackle the current crisis, and prevent a higher level of mental health need – with all the concomitant social costs – in the future. The foundations provided by the £500m COVID-19 recovery funding need to be built upon in the coming years to ensure Long Term Plan trajectories are restored, the demand arising from the pandemic can begin to be addressed, the Mental Health Act reforms implemented successfully and the waiting time targets arising from the Clinical Review of Standards introduced effectively. This additional settlement should be at least £1bn in 2022/23, £1.5bn in 2023/24 and £2.4bn in 2024/25.

We had expected that the 2021 Comprehensive Spending Review would set Government Departments' capital and resource budgets for the years 2022/23 to 2024/25. However, on 7<sup>th</sup> September 2021 the Government published a plan for health and social care, alongside an announcement of a new levy to raise funds. Build Back Better outlines that £15.5bn has been committed for NHS recovery over the next three years, including £8bn to clear the Covid backlog, while 9.1bn will go to DHSC.<sup>14</sup> It is as yet unclear whether this constitutes the entirety of the health revenue spending for 2022-2025. The Health Foundation estimates it will cost up to £16.8bn to 2024/25 to enable the NHS to clear the backlog of people waiting for routine elective care, return to 18 week waiting time targets, and treat millions of 'missing' patients who were expected to receive care during the pandemic but did not.<sup>15</sup> We urge that mental health gets a fair proportion of this funding already committed, and of forthcoming Spending Review announcements, as per the exigencies of parity, existing commitments, and the Mental Health Investment Standard - ensuring that spending on mental health continues to increase as a share of clinical commissioning group allocations in the coming years.

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

### **Capital investment in the mental health estate is urgently needed**

When the NHS was founded in 1948 its estate was made up of around 3,000 hospitals, many of which required urgent improvement and reorganisation. After just two major injections of capital funding in the 1960s and 2000s, the Naylor Review in 2017 sought to identify opportunities to rebuild NHS infrastructure to meet modern standards of service delivery fit for the future. The Review concluded that without investment in the NHS estate, the Five Year Forward View could not be delivered, and the estate would remain unfit for purpose and continue to deteriorate.<sup>16</sup>

Across the 50 NHS mental health trusts in England<sup>17</sup>, much of the estate still meets that description, posing serious challenges to those who receive treatment and care and to those who work in those facilities.<sup>18</sup> These challenges are not merely confined to those around health and safety, but also relate to the estate being therapeutically poor in many areas and adversely impacting upon the wellbeing of the workforce. This situation was clear prior to the arrival of COVID-19, however the pandemic threw into sharp relief the need for urgent capital investment in the mental health estate.

Many buildings have been designed to address safety concerns, such as fire, self-harming and violence, but not infection prevention and control. It is paramount that mental health services prevent nosocomial (in hospital) transmission of COVID-19 and any other viruses/infections in inpatient settings, as well as preventing spread in the community. People who have a mental illness are also more likely to have poorer physical health than the general population, making them more susceptible to the virus.<sup>19</sup> This includes higher rates of smoking, respiratory disease (COPD, asthma, chest infections), substance use disorders, as well as malnourishment caused by metabolic problems or eating disorders. So, inpatient settings taking action to address infection control is especially important. This has been underlined by recent research by Read and colleagues that estimated just over two-thirds of COVID-19 cases (67.5%) within mental health hospitals in the first wave of the pandemic were acquired within those facilities, compared to just under one in ten (9.7%) within acute and general hospital settings.<sup>20</sup> Protecting both patients and staff requires different ways of working from usual practices, but would prevent significant morbidity and mortality, and reduce the pressure on acute physical health services.

The College co-produced guidance with NHSE/I for inpatient settings in spring 2020, which recommended that clinicians should ‘cohort’ (separate) patients into those with confirmed COVID-19 and those without confirmed COVID-19.<sup>21,22</sup> The guidance was clear that providers should reconfigure the inpatient estate to enable ‘cohorted’ wards to reduce the risk of contagion. Providers were asked to consider:

- how additional, single-room accommodation for patients with the COVID-19 virus could be provided in partnership with the independent sector (which may offer a higher proportion of single-room accommodation)
- whether modifying any available capacity within the adult secure estate is possible, to accommodate voluntary patients, and
- analysing and mapping the current inpatient estate to identify key gaps, risks and pressures and developing a number of contingency plans to match likely scenarios, in partnership with other inpatient providers locally.<sup>23,24</sup>

The guidance also outlined that for mental healthcare professionals working in the community, there needed to be sufficient and appropriate space for staff to socially distance, don and doff PPE, carry out hand washing, showering or change clothing in order to follow infection prevention and control guidance. Yet, our members in some areas reported this was not able to happen because of limited real estate capacity, or lack of strategic planning.<sup>25</sup>

There has been a longstanding and acknowledged deficit in the quality of mental health estates in the NHS. Such deficits have only been notable during a time of significant systemic stress.

Lack of single rooms has led to spread of virus between patients

No place to do proper donning and doffing of PPE. No handsfree handwash like in theatres and acute hospitals. No space for social distancing. No space for patients to isolate...basically a [pandemic] disaster waiting to happen.

It's not fully possible to zone inpatient wards into red/amber/green areas as we cannot physically separate areas and bedrooms are not en-suite.

We have 4 bedded dormitories so patients can't be isolated or shielded. We only have 3 single rooms.

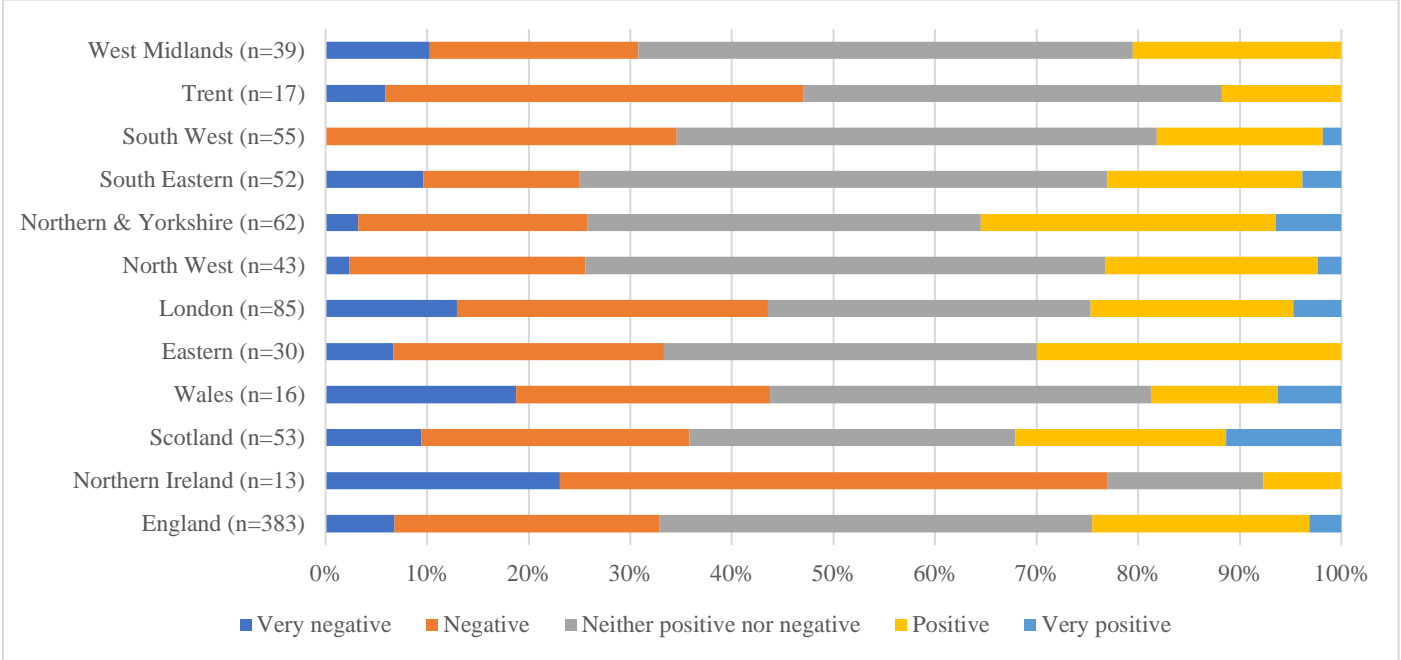
COVID-19 spread rapidly on my ward in March. Six patients and multiple staff tested positive. Most patients were in bays. Only one side room has an en-suite.

*Free text comments received from RCPsych members  
(June 2020 membership survey).*

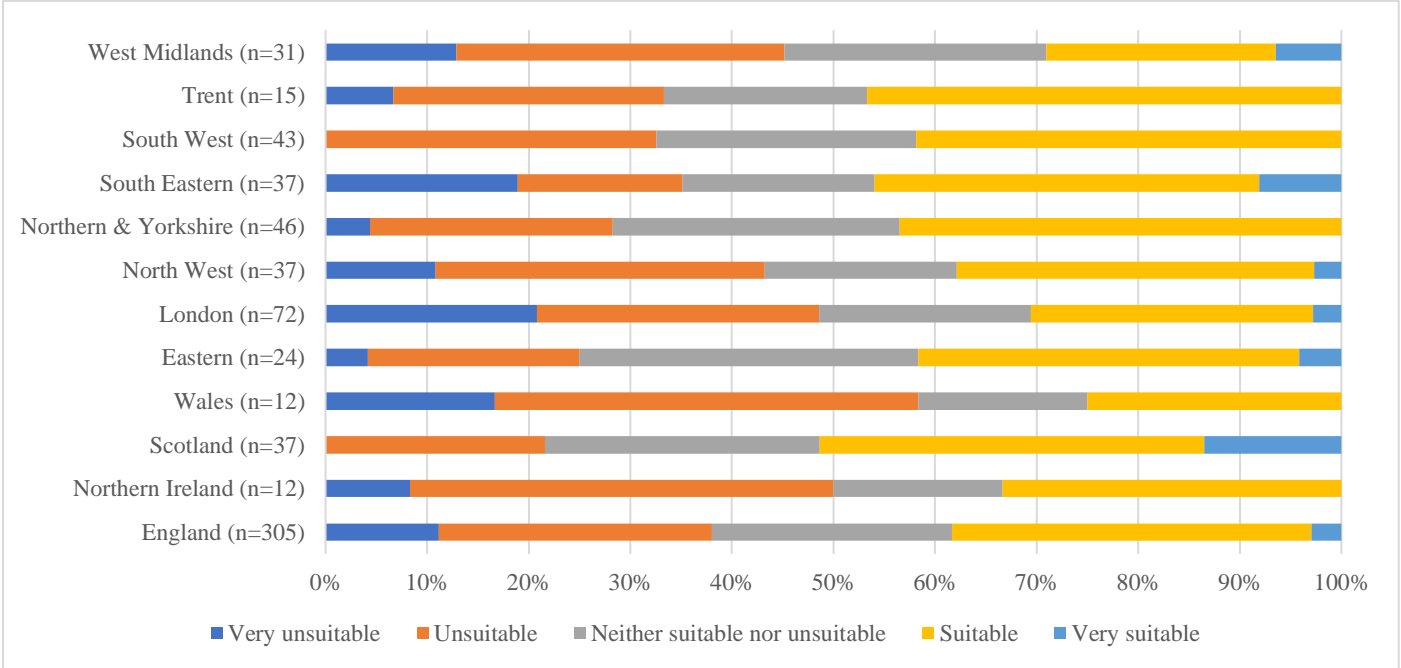
Our membership survey in June 2020 found that 32.9% of clinicians said that the quality of buildings and estates in their organisation has negatively or very negatively impacted upon the care provided to patients during the pandemic (Chart 1 below).<sup>26</sup>

Furthermore, 38% of members said that their organisations' estate has been unsuitable or very unsuitable for the cohorting of patients with suspected or confirmed COVID-19 (Chart 2). Conversely, it was clear that where the mental health estate has been modernised, it has had a positive impact on both patients and staff during the pandemic.<sup>27</sup>

**Chart 1. What impact has the quality of buildings and estates in your organisation had upon the care provided to patients during the pandemic?**



**Chart 2. How suitable have the estates been in your organisation for the cohorting of patients with suspected or confirmed COVID-19?**



Relevant comments provided by members that demonstrate the value of estate investment included the following:

“New built inpatient unit on same site as acute, all single rooms and we had flexibility of being able to partition wards and flex beds up and down.”

“Due to number of wards and newness of buildings, they are easy to clean and also able to split ward into COVID positive, negative and new admissions awaiting testing.”

By contrast, challenges with cohorting were described as below:

“Some rooms are too small for social distancing when seeing patients. It is paramount that all offices and clinical areas are cleaned regularly. I am unsure if the right protocols for this are in place.”

“A COVID ward was identified within the organisation. However, this was done rather late, when virtually every ward in the organisation had anything between 2-6 patients who were unwell with COVID. My ward is an old style ward on an acute hospital site with 4-bedded bays, and only 2 side rooms, so it became challenging to manage COVID positive unwell patients, and we had to quickly make other changes such as converting a communal quiet room into a third side room.”

In addition to the need to cohort patients, space is also required for education/ training of NHS staff as well as conducting different types of research. On NHS mental health sites, there is competition for clinic rooms for quiet spaces to do this work, and there may be a need for equipment to be maintained or access to medicine and/or lab-like facilities. Pressures on clinic space are only likely to increase as the workforce continues to grow, especially as pandemic related factors still need to be considered including interpersonal proximity, ventilation, and how to manage vulnerable participants or staff. When reconfiguring or building new spaces for research and education these factors must be taken into account.

In sum, pandemic control measures need a full assessment in the community office and the community clinical estate, as well as in the inpatient and crisis environment, to ensure the mental health estate can be more suitable for any future waves of COVID-19 or similar pandemics in the future.

### *Infrastructure projects*

The Health Infrastructure Plan (HIP) is a five-year rolling programme of investment in NHS infrastructure taking a strategic approach to improving hospitals, primary and community care estates and health infrastructure, with waves of investment in new infrastructure initiatives.<sup>28</sup> The programme is supported by the Government’s new national construction framework, ProCure 2020, which is working with new hospital building projects up until 2030.<sup>29</sup>

We understand the existing HIP capital projects were selected by looking at priorities within Integrated Care Systems (ICSs); looking at those parts of the estate which are the oldest and most operational issues; and those that were most advanced in the scoping and planning process.<sup>30</sup> A mere two of the 40 schemes confirmed in October 2020 were for mental health trusts.<sup>31</sup>

There were 205 other proposals across Sustainability and Transformation Partnerships (STPs) outside of HIP1 (2020-2025) and HIP2 (2025-2030), but between July 2017 and June 2020, just 11 mental health trusts received STP full business case approval for 16 infrastructure projects, totalling £68.6m Public Dividend Capital allocations.<sup>32</sup>

The ongoing next phase of HIP<sup>33</sup>, inviting trusts to compete for investment in a further eight projects, must therefore afford sufficient priority to mental health facilities. We are making the case in this submission for a Mental Health Infrastructure Plan that would ultimately fund 12 hospitals/schemes over the period to 2030. This competition provides the opportunity to deliver on the first half of this programme by funding an initial six projects.

### *Capital investment by Government and DHSC*

In 2019/20, the DHSC spent a net £7.0bn on NHS capital – 64% of which was spent by NHS trusts in England.<sup>34</sup>

The Spending Review 2020 confirmed ‘multi-year funding to build 40 new hospitals and upgrade 70 more by 2030’, alongside £4.2bn for hospitals ‘to refurbish and maintain their infrastructure’, £559m ‘to support the modernisation of technology across the health and care system’ and £165m towards the investment programme to eradicate mental health dormitories.<sup>35</sup> The latter was in addition to an initial tranche of £250m

announced in July for 2020/21 ‘to make progress’ on replacing dormitories with ‘1300 single bedrooms across 25 mental health providers.’<sup>36</sup>

The Spending Round in 2019 had previously committed to upgrade 20 hospitals and was underpinned by £854m of new funding, alongside a £1bn boost to NHS capital spending in 2019/20 via the HIP.<sup>37, 38</sup>

### *Capital expenditure by NHS trusts*

In 2018/19, mental health trusts accounted for 12% of all capital spending by trusts, acute trusts for 76% and specialist trusts for 7%.<sup>39</sup> By comparison, turnover shares in the same year were 15% for mental health trusts, 75% for acute trusts and 5% for specialist trusts.<sup>40</sup>

In 2020/21, while capital expenditure was ultimately below planned levels across all NHS trust types (with the exception of ambulance trusts), it was within mental health trusts where the shortfall was greatest in percentage terms. Capital spend amounted to only £383.8m in 2020/21 – 24.5% below the planned £508.5m. This compares to 7.5% below planned spend across all trusts, 16.3% within specialist acute trusts, 14.3% for community trusts and 3.9% within non-specialist acute trusts.<sup>41</sup> This follows greater shortfalls against planned capital investment in the most recently available data. Capital spending amounted to only £481m in 2018/19 – 28.0% below the planned £668m and compared to 15.3% shortfall across the provider sector,<sup>42</sup> while the shortfall in 2017/18 for mental health trusts was 38.9% (£280m invested against a plan of £458m) compared to 29.1% for all trusts.<sup>43</sup>

For 2021/22, NHSE/I have confirmed a net increase of around £400m funding for NHS operational capital. This means the NHS provider capital allocation for 2021/22 has been set at £6.2bn, compared to a forecast outturn of £5.8bn in 2020/21.

NHSE/I state that NHS provider capital allocation will be split as follows:

1. **System-level allocation** (£3.9bn) – to cover day-to-day operational investments (which have typically been self-financed by organisations in ICS/STP or financed by the DHSC through emergency loans). This allocation includes funding for critical infrastructure risk, high and severe risk reinforced autoclaved aerated concrete hospitals, diagnostic equipment and COVID-19 responses.
2. **Nationally allocated funds** (£1.2bn) – to cover nationally strategic projects already announced and in development and/or construction such as hospital upgrades (STP capital funded schemes) and new hospitals.
3. **Other national capital investment** (£1.1bn) – including national programmes such as community diagnostic hubs, national technology funding and the continuation of the Mental Health Dormitory Replacement Programme started in 2020/21.<sup>44</sup>

ICSs are responsible for system transformation and collective management of system performance. This includes capital and estates plans at a system level. This will make for more complex and time-consuming negotiations between system partners and will be impacted by the maturity of ICSs.

As NHSE/I ask *all* NHS providers to submit estate plans taking account of their known funding sources and schemes that have already received DHSC funding approvals, including STP capital programmes<sup>45</sup>, we are concerned that NHS mental health providers will lose out – as they have historically – unless concerted, targeted action is taken. As noted above, mental health providers often receive a disproportionately lower amount of capital funding compared to other providers across the local health economy.<sup>46, 47</sup> One solution is for the Health and Social Care Bill wording to ensure mental health trust representation on ICS boards, to ensure a stronger voice for mental health when decisions are being made about investment across the ICS area. However, we would also welcome other concerted action to address capital funding parity.



There are other concerns relating to capital to revenue transfer, resulting in mental health trust capital budgets having been consistently squeezed in-year to plug deficits elsewhere in the NHS budget, thus reducing the total amount available to system providers within a given year.

### *Capital expenditure on digital*

The 2020 Spending Review committed £559 million to support the modernisation of technology across the health and care system.

NHSX has committed funding to address digital inequalities across clinical pathways, to support ICSs that have an active interest in addressing digital equalities within their clinical pathways. This is a positive development, but with little funding and few areas eligible (just £120,000/10 clinical areas), we are concerned this will not make a significant difference within mental health. One example among many where more substantial investment is urgently needed is around the interoperability of electronic patient records (EPRs) between mental health and acute trusts. This current lack of connectivity between EPRs is having an adverse impact on patient outcomes.

Earlier in 2021, NHSX launched a new digital playbook on mental health to help clinical teams reimagine and redesign how patients receive care. It is one of a set of playbooks that look at how technology is being used to solve common challenges in delivering care across the NHS, ensuring that patients can benefit from the latest digital developments in their treatment. The playbook incorporates: the role and benefits of digital technology in delivering better mental health pathways; experiences of those who have implemented digital into mental health services and the successes and challenges, and links to the wide range of trusted digital tools available to clinicians.

The playbooks aim to support the NHS's commitment, set out in the NHS Long Term Plan, to reduce face-to-face outpatient appointments by up to a third over the next five years and make digitally-enabled primary and outpatient care mainstream across the NHS.<sup>48</sup>

Another area of innovation has been the Global Digital Exemplars (GDE) programme which included seven digitally advanced mental health trusts delivering exceptional care efficiently, using world-class digital technology and information, being supported to become GDEs.

Eight Mental Health Trusts were selected as Digital Aspirants, out of a total of 59 chosen to participate. Mental Health Trusts therefore make up just 13.5% of participating trusts, whereas they make up 23% of all Trusts (50 Mental Health Trusts out of 213 acute non-specialist, acute specialist, community, and ambulance Trusts). Mental Health Trusts are therefore underrepresented in the Digital Aspirant Programme.,

Blueprints have subsequently been developed to help other NHS Trusts deliver digital capabilities more quickly and cost effectively than was possible in the past.<sup>49</sup>

The Digital Aspirant programme is targeted at supporting those providers outside the GDE network to get the core digital capabilities they need to deliver safe, high-quality and efficient care, providing substantial funding for full participants, and seed funding for others. Twenty-three trusts were selected in the first wave of the Digital Aspirant programme with £28 million of funding for their first year. In March 2021 an additional 32 trusts joined the programme. Seven of these will also receive up to £6m over the next three years, while the remaining 25 are receiving funding of just £250,000 to develop their digital strategy and business case.

The Innovation and Technology Payment (ITP) programme supports the NHS to adopt innovations by removing some of the financial and procurement barriers to introducing new technologies. It is a competitive process for innovations and technologies that have already proved their clinical effectiveness and are ready to be rolled out nationally. Amongst the themes receiving support is one on mental health: Digital apps to support emergency/crisis mental health assessments, receiving funding via the Evidence Generation Fund.



## *Reasons why capital investment in mental health services is urgently needed*

- *Ensuring the safety of patients and staff*

The Independent Review of the Mental Health Act found that patients in mental health facilities are often placed in some of the worst places in the NHS estate. The Review found that badly designed, dilapidated buildings and poor facilities are not a safe place for staff to work and for patients can contribute to a sense of containment atmosphere and make it hard for effective engagement in therapeutic activities.<sup>50</sup>

The Care Quality Commission's State of Care report on mental health found that many mental health wards are unsafe and provide poor quality care in old and unsuitable buildings. The CQC argue that the design of many of these buildings do not permit staff to observe all areas easily and many wards contained fixtures and fittings that people who are at risk of suicide could use as ligature anchor points.<sup>51</sup>

NHS Providers' analysis also showed the continued under-prioritisation of investment in the mental health estate is having a demonstrable impact on patients.<sup>52</sup> There were seven never events reported in mental health trusts in 2018 as a result of a shower/curtain rail failing to collapse.<sup>53</sup>

The 2019 NHS staff survey (the most recent iteration that included this question) showed that more than one in five workers in mental health trusts witnessed an error, near miss or incident that could have hurt a member of staff in the last month.<sup>54</sup> Safety concerns raised by RCPsych members have included a lack of safe places for clinical assessments, a lack of a proper alarm system and unsafe procedures/protections for handling toxic or dangerous products such as used needles.

The CQC also found that sexual safety incidents are common on mental health wards and affect not only service users, but also staff and visitors.<sup>55</sup> Following a review of incident reports on NHS mental health wards over a 3-month period in 2017, they found that 1.6% were related to sexual safety. The National Collaborating Centre for Mental Health (NCCMH) is developing standards and guidance on improving sexual safety in inpatient environments as part of a Collaborative. Through their ongoing work, they have identified that mixed sex accommodation still exists across the country and significant investment and assurances to prevent out of-area admissions would be required for these to be completely eliminated.<sup>56</sup>

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. Of the 50 mental health trusts rated by the CQC as of August 2021, only 46.0% are rated as good on safety (none as outstanding), which is better than the non-specialist acute sector at 25.4%, but also remains well below community trusts (66.7%).<sup>57</sup> The biggest concerns relate to the poor physical environment, restrictive interventions, sexual safety, safe medicines management and low staffing levels. A mere 32.1% of all trusts with acute wards for working age adults and psychiatric intensive care have secured good or outstanding ratings for the safety of those facilities. Despite this, currently, 78.0% of mental health trusts are rated as good or outstanding for being well-led and 2.0% are rated as inadequate. This compares to the non-specialist acute sector where 61.5% are good or outstanding and 4.1% are rated as inadequate.<sup>58</sup>

Building on this foundation, the Government should aim to make mental health services in England among the safest in the world.

- *Ensuring the built environment supports patient outcomes and recovery*

Every patient wants the best chance possible to get better. Improving the mental health estate requires a concerted focus on reducing harm, but there are also opportunities to think innovatively and improve the quality of the environment that goes beyond harm reduction so that it makes a positive impact on a patient's health.

The vast majority of mental health care is delivered in the community. This occurs in clinics, psychological therapies, group work, 1-2-1 support for people with a mental illness, intellectual disability and neuropsychiatric disorders. The environment is the first indication of the value we place on people; the place where difficult memories are recounted, and hard conversations are had. It is where prevention happens, where escalation into crisis is avoided and where healing and recovery may begin.

For those people who do need a hospital admission, many mental health hospitals are unable to provide a therapeutic environment and to maintain privacy and dignity. Patients admitted are often detained under the Mental Health Act 1983, and have longer admissions than patients in general hospitals, so having a high-quality therapeutic environment is essential. The provision of gym facilities as well as facilities for gardening and outdoor sports as part of inpatient wards is very beneficial. This is important considering the fact that most of the inpatient wards have become non-smoking areas.

Any new capital project also needs to consider the huge impact mental illness has on an entire family network and include innovative ways to ensure those who use inpatient services are able to access their family and private life during their inpatient stay. Many inpatient services have had to deal with real challenge as carers, family members and parents were unable to visit during the height of the COVID-19 pandemic, and visiting policies are likely to be altered for many months.

We commissioned a report in 2019 which identified the need for additional inpatient beds in some areas of the country to meet the recommended rate of 85 per cent bed occupancy across all STPs and reduce out of area placements.<sup>59</sup> A programme is already underway to commission more CAMHS tier 4 beds, secure care beds and mother and baby units, which has been well received.<sup>60</sup>

There is also a need to ensure the mental health/learning disability estate (both inpatient and community) is autistic-friendly and fit to accommodate patients with disabilities, including but not limited to the frail elderly. Patients with a wide range of physical, cognitive, auditory, visual, sensory and other disabilities need to be able to access and benefit from mental health and learning disability/autism services. This is likely to become increasingly important with an ageing population with multiple morbidities.

For patients who are presenting via an emergency route, safe and appropriate spaces in A&E as well as appropriate mental health transport vehicles, is essential. The Independent Review of the Mental Health Act made the following recommendations to local areas:

- alternative forms of provision for those in crisis or requiring a mental health inpatient admission e.g. sanctuaries; safe havens and crisis cafes; crisis houses
- new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E, and
- appropriate assessment spaces in A&Es for people with mental health needs.

The NHS Mental Health Implementation Plan states that every area will be expected to increase the range of services available locally that provide an alternative to an admission. The alternative services will require co-production with service users, recruitment of peer support workers, a prominent role for local voluntary sector organisations, and will be expected to include options that are tailored to meet needs of specific locally identified priority demographics and inequalities.<sup>61</sup>

- ***Ensuring the built environment contributes to staff morale and increases retention***

The built environment can severely affect not just the health and wellbeing of patients, but also of staff. NHS leaders have recently highlighted this in calling for increased capital investment.<sup>62</sup> We know that working in new modern buildings makes a huge difference to morale. Improved facilities contribute to feelings of morale, pride as well as productivity,<sup>63</sup> and could potentially contribute to improving poor public perceptions of working in mental health.<sup>64</sup>

Research has also demonstrated the importance of green space and access to nature for people's mental health and wellbeing. These findings suggest that the inclusion of green space in the development of the healthcare built environment would be positive in supporting the wellbeing of both patients and staff.<sup>65</sup>

As the NHS attempts to become a better place to work through a new Core Offer, including action to support the changes healthcare professional say will make a positive difference to their working lives and experiences, the role of mental health buildings and the wider estate should play a key part.<sup>66</sup>

- *Ensuring mental health trusts are sustainably designed*

The NHS Sustainable Development Unit (SDU) defined a sustainable healthcare sector as one that involves 'greening' the sector with attention to energy, travel, waste, procurement, water, infrastructure adaptation and buildings. This ensures resources (physical, financial and human) used in the sector are used efficiently (e.g. buildings are well insulated and use less fuel to heat) and used responsibly (e.g. clinical waste is disposed of safely to protect local people).<sup>67</sup>

The NHS LTP set out several environmental and sustainability targets, which are outlined below:

- by 2025, the NHS will reduce our carbon footprint by 51% against 2007 levels, by greening our estates and facilities, including phasing out coal and oil fuel as primary heating
- by 2023/24, the NHS will cut business mileages and fleet air pollutant emissions by 20%, and
- the NHS will deliver reductions in single use plastics throughout the NHS supply chain.<sup>68</sup>

Replacing ageing buildings across mental health trusts will help Government meet the NHS' environmental and sustainability targets and improve its response to the climate and ecological emergencies.

In addition to sustainability, there are opportunities for mental health trusts to embed nature within service design, which will have a positive impact on mental and physical health. Appendix 1 includes a case study of a Woodland Retreat which seeks to do this. Another example is a joint initiative between Lancashire and South Cumbria NHS Foundation Trust and The Lancashire Wildlife Trust which has to date empowered almost 260 young people, in the Preston, Chorley and East Lancashire areas (aged 13 to 24 years) to take action within their local greenspaces that both improves their health and wellbeing as well as benefitting their local community. The aim of the project is to support 1,000 young people in central and east Lancashire to participate in outdoor ecotherapy based activities that improve their mental health and physical wellbeing.<sup>[69]</sup>

In the year when the UK hosts the 26th UN Climate Change Conference of the Parties (COP26) it is essential that green design, and green estate are prioritised, contributing simultaneously to climate change limitation, and nature-informed approaches to healing and wellbeing.

- *Ensuring services have the digital capabilities they need to optimise care*

Investment in technology can improve care, increase productivity and release staff time. The COVID-19 pandemic has rapidly accelerated the use of technology in healthcare provision, with remote working and consultations becoming increasingly widespread across mental health services. The 2020 Spending Review committed £559m to support the modernisation of technology across the health and care system. As we emerge from the peak of the pandemic, action will be needed to evaluate and embed progress to date. Further investment will also be needed to maintain progress and address ongoing issues that affect patient care, such as issues with IT system interoperability.

Growing digital literacy among patients and digital capability in services has enabled more routine use of remote consultation – a new way for patients to engage with services and speak to clinicians. 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. This trend was significantly accelerated during the pandemic. While digital consultations can improve accessibility of care

for those with mobility/transport difficulties or practical concerns, they can also help to reduce costs. However, remote consultations 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. Both the therapeutic relationship and clinical appropriateness mean that digital appointments are sometimes inappropriate and should not be the only option available to access care.

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>69</sup> This should be reflected in the training curriculum, with part of the research funding advocated for in this submission also potentially utilised to evaluate patient experience of digital consultations among these patient groups in particular.

### *Capital investment in mental health: actions needed*

Building on the rationale outlined above, we have identified five actions for NHS mental health providers and CCGs, followed by recommendations for the Government and NHS ALBs. In order to be able to meet these actions, sufficient investment from Government, DHSC and NHSE/I will be needed.

#### **Action 1: NHS mental health trusts to complete the replacement of dormitory accommodation with single en-suite rooms**

CQC data published by the Health Service Journal in June 2019 showed that around 7% of mental health beds were still located within dormitories, equivalent to 1,176 beds across more than 300 wards nationwide.<sup>70</sup> Around 64% of the beds are on adult acute wards and psychiatric intensive care units with 36% for older adults with mental health needs.

The five trusts with the greatest amount of dormitory provision were found to be:

1. Leicestershire Partnership NHS Trust – 166 beds on 39 wards
2. Greater Manchester Mental Health NHS Foundation Trust – 134 beds on 35 wards
3. Derbyshire Healthcare NHS Foundation Trust – 130 beds on 36 wards
4. Essex Partnership University NHS Foundation Trust – 76 beds on 18 wards
5. Sussex Partnership NHS Foundation Trust – 71 beds on 22 wards.<sup>71</sup>

The College has very much welcomed the £415m already announced by the DHSC towards the replacement of dormitories with single en-suite rooms, with four of the five trusts listed above among the 21 trusts confirmed to be receiving funds.<sup>72</sup> It was recently confirmed that as of May 2021, there were still 1,135 dormitory beds in place across England<sup>73</sup> so the need for this investment to be reaffirmed over the first two years of the SR period is crucial to ensure this programme is delivered as planned.

Case studies of trusts that have replaced their dormitory accommodation are provided in Appendix 1.

#### **Action 2: Mental health trusts to improve the accessibility and therapeutic environment of inpatient wards**

##### *Same-sex accommodation*

All providers of NHS funded care are expected to eliminate mixed-sex accommodation to ensure the safety, privacy and dignity of patients is prioritised. Reporting breaches of the same-sex accommodation policy has been mandatory for providers since 2011.<sup>74</sup>

A breach will have occurred if:

- patients have to share sleeping accommodation with members of the opposite sex
- patients have to share toilet or bathroom facilities with members of the opposite sex
- patients have to walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms (this excludes corridors), and
- women do not have access to women-only day rooms in mental health inpatient units.

These current rules allow mixed corridors and other shared spaces on the same ward<sup>75</sup> but mental health providers should look for improvements that go further than the technical definition of same sex accommodation.

According to data obtained by the Health Service Journal in 2020, there were a total of 668 mixed sex wards and more than 803 mixed sex communal areas, from the 47 trusts that responded.<sup>76</sup>

NHSE/I advise that non-permanent structure changes to the estate can support the delivery of same sex accommodation where the partition is solid, opaque and floor to ceiling, and protects the privacy and dignity of the individual patient.<sup>77</sup> Providers will also need to ensure suitable accommodation is available for patients who identify as non-binary.

### *En-suite facilities*

Providing single rooms with en-suite facilities (including shower/bath, sink and toilet) will improve privacy and dignity during an inpatient stay. The 2019/20 Estates Return Information Collection (ERIC) confirmed there were 6,596 single rooms without en-suite facilities in mental health and learning disabilities sites across 57 NHS trusts and foundation trusts. This represents 34.9% of the 18,904 single rooms available in those three types of site. By way of comparison, the proportion of single rooms without en-suite facilities across all other site types combined was 32.1% (12,069 of 37,639).<sup>78</sup>

16 of the 57 trusts mentioned above confirmed that at least 50% of their single rooms did not have en-suite facilities. The highest percentages in trusts with more than 50 single rooms were found to be:

1. Dudley and Walsall Mental Health Partnership NHS Trust – 98.5% (135 of 137)
2. Leeds and York Partnership NHS Foundation Trust – 82.3% (345 of 419)
3. Worcestershire Health and Care NHS Trust – 73.6% (64 of 87)
4. Oxleas NHS Foundation Trust – 71.9% (189 of 263)
5. South London and Maudsley NHS Foundation Trust – 69.0% (593 of 860).<sup>79</sup>

Case studies are provided in Appendix 1.

## **Action 3: Mental health providers to procure and/or develop property to support modern, integrated mental health services**

### *Clinical and office space*

The LTP Mental Health programme aims to deliver high quality, evidence-based mental health services to an additional 2 million people.<sup>80</sup> An additional 27,460 staff working in mental health services, on top of the commitments from Stepping Forward (an objective of 19,000 additional staff by 2020/21) by 2023/24 will mean more clinical space, as well as office and workspace, will be required, predominantly in the community.<sup>81</sup> Both clinical and office space are crucial and can be barriers to pathways of care in the case of poorly designed or poorly procured clinical space in the community, hindering both the quality and quantity of community-based treatment on offer.

Community based clinicians have expressed frustration at the lack of adequate and well-equipped space to provide care and do administrative work. Some have mentioned that the pandemic has exacerbated this, with the requirements for social distancing and improved IPC infection prevention and control measures making things more difficult. For example, challenges reinstating support group sessions due to a lack of space related to social distancing measures, or ventilation being difficult in buildings where it is not possible to open windows for fresh air due to concerns over patient privacy.



A lack of a working environment that is equipped to carry out even basic healthcare checks (for example spaces with sinks, storage etc) has also been raised as an issue, as well as rooms often not being welcoming environments for patients. Clinicians have mentioned having to work from home, with whole team meetings being difficult or even impossible due to a lack of space. It has been raised that implementing an expanded multi-disciplinary team (MDT) approach as intended through the community transformation programme is going to be very difficult as services often will be without the environment to bring the team together physically, and this could affect team members' relationship building, communication, and decision-making.

It has also been expressed that in integrating more closely with primary care, with mental health professionals spending more time working closely with GP practices, that issues around physical space to practise and work also continue to arise. Primary care being a centre point for other community health services is a useful aim, but without adequate thought and resourcing being given to how primary care sites will cope with needing to support expanded MDTs from their bases, there is a risk of negative impact for both clinicians and patients.

There has been the sense that infrastructure such as adequately equipped and welcoming clinic rooms for patients, office space for both existing and new staff, and IT systems and equipment is not in place in many areas and is hindering the rollout of community transformation. Community mental health teams for adults, children and young people and older adults provide core mental health services and it is essential that they are operating in an environment where they can work at their best. The following considerations need to be given to all the community team bases:

- welcoming and well-equipped clinical space, including facilities to organise physical health screening
- space and purpose-built rooms for group therapies, gym etc
- provision of telemedicine facilities to undertake video/remote review of patients
- space for staff meetings, in house training, reflective practice sessions and continuing professional development
- desks or offices for staff members
- adequate car parking spaces for staff and patients using the site, and
- spaces ideally located close to the community as well as easy access to the primary care settings.

### ***Alternative crisis provision***

The Independent Review of the Mental Health Act recommended that by 2023/24, investment in health-based places of safety should allow for the removal of police cells as a place of safety. This is subject to satisfactory and safe alternative health-based places of safety being in place.<sup>82</sup>

NHSE/I require mental health providers to procure alternative forms of provision for those in crisis or requiring a mental health inpatient admission, such as sanctuaries, safe havens, crisis cafes or crisis houses. There are currently very limited number of crisis houses or sanctuaries around England and this provision is not well documented.<sup>83</sup>

It is important that any alternative crisis provision is age-appropriate and so for children and young people that should also include a range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways.

A comprehensive set of case studies on a range of crisis and acute mental health 'alternative' provision that complement traditional NHS crisis teams and acute inpatient services have been put together by NHSE/I.<sup>84</sup>

### ***Assessment spaces in A&E and acute hospitals***

Ideally, A&E ought to be a safe space for people experiencing mental health crisis. Whereas in reality, A&E can be a stressful environment for any patient but particularly so for those who are feeling paranoid,

psychotic, distraught or suicidal.<sup>85</sup> According to the Psychiatric Liaison Accreditation Network (PLAN) at the College, a safe space should mean there are no ligature points and nothing that can be used as a weapon. The room should have an alarm system and two doors that open both ways. It is not acceptable to use a room that doubles as an office. PLAN identifies that a patient may be observed in a different space to where they undergo assessment by the mental health team and departments should consider how they can make these spaces as safe, quiet, and calm as possible. A brief risk assessment of the environment should be made whenever a patient is at risk of self-harm is put in a cubicle.<sup>86</sup>

PLAN estimates that just 23% of type 1 A&Es (175 in total) meet their standards for physical environment. Having an assessment space that doubles as an office is the most common reason why a liaison service does not achieve full PLAN accreditation.<sup>87</sup> As such, there is a significant lack of psychiatric assessment rooms in many A&Es that are adequately equipped, which compromises patient safety and privacy.

During the pandemic, Mental Health A&Es were established over many parts of the country. According to the College's Faculty of Liaison Psychiatry, there is interest in maintaining alternative care pathways and facilities for patients who present with mental health problems, rather than them being assessed in traditional A&E. However, many such units have been created with limited planning and resources and are in facilities that are not fit for purpose in the long run. If this is to be the desired model in some parts of the country, longer term establishment of such units will require capital and revenue funding.

The pandemic has also led to a significant increase in both the number of children and young people presenting to A&Es in crisis, and their level of acuity. Data suggests that children and young people are much more likely to be admitted to a paediatric or general ward after presenting to A&E in crisis than adults, partially because of the difficulty in accessing age-appropriate assessments due to a lack of under-18s liaison services and particular challenges associated with assessing children and young people in a busy A&E environment. Investment in appropriate spaces in which children and young people can be assessed, where safeguarding needs are met and where links with social care and other services can be built would dramatically improve patient experience, likely contribute to a reduction in avoidable admission and repeat presentation to A&E. Investment in under-18 liaison services is also critical to ensuring those children with mental health needs that are admitted onto acute wards receive necessary mental health support, can be discharged appropriately, and support the delivery of forthcoming mental health waiting time standards.

In acute hospitals there is rarely enough space to conduct clinics comfortably, so integrating psychological services into those clinics, even when a service has been commissioned to do so, can be almost impossible. There needs to be a mixture of dedicated space in a department of liaison psychiatry, and enough space in clinics, that patients can see a mental health professional as part of the integrated care they receive in that visit.

### ***Mental health transport vehicles and integration of mental and physical health in ambulances***

A large proportion of ambulance call-outs and ED attendances relate to mental health emergencies, demonstrating the need for ambulance services to be integrated to cope fully with mental and physical crises. Ambulance and emergency medicine staff behaviour and clinical skills, the ambulance fleet, and emergency department facilities must be fit for purpose to serve mental health and physical health needs side-by-side in integrated services (including the 'safe spaces' outlined above).

Given the high prevalence of co-occurring mental health and physical health needs, and the need to address stigma and discrimination within health care services, the overall direction of travel should be to greater integration of emergency physical and mental health care response, rather than segregation.

Feedback from patients is that medical needs are often overlooked or missed altogether during emergencies. Where emergency mental health services are segregated – either as a separate ambulance fleet or separate emergency facilities - it is important that this situation is not made worse.

Despite this, there are instances where suitable transport vehicles will be needed to prevent police conveyance to A&E. For instance, Secure24 is an organisation that operates secure patient ambulance

transport and support services and work with several mental health trusts, local authorities, the independent health sector and the police service. For persons of any age deemed to have a low to no risk, they offer a multi-person vehicle with two trained members staff and conference style seating making it easier for staff to monitor and attend service users, and there is a clear Perspex shield protecting the driver.

## **Action 4: Mental health trusts to replace ageing buildings**

### ***Age of the mental health estate***

More than 800,000 square metres (805,416) of the mental health trust estate in 2019/20 (based on 'gross internal site floor area', the 'total internal floor area of all buildings, occupied or unoccupied') was built before the NHS existed.<sup>88</sup> This represents 18.1% of the overall mental health trust estate, compared to 12.3% of the entire trust estate at that time (measured in terms of 'gross internal site floor area'). Other percentages by trust type are: acute non-specialist – 10.1%; specialist acute – 25.9%; community – 23.1%; and ambulance – 4.2%).

Alternatively, if we look at mental health and learning disability sites (not available when this was last reported on by NHS Digital), the proportion built before the NHS was established is 16.8%. This can be compared to 8.9% of general acute sites, 19.9% of specialist hospital sites and 18.5% of community hospital sites.<sup>89</sup>

The following mental health trusts were found to have the highest percentage of estate built before 1948 when figures were reported for 2019/20:

1. Tavistock and Portman NHS Foundation Trust – 80.0%
2. South London and Maudsley NHS Foundation Trust – 51.6%
3. Berkshire Healthcare NHS Foundation Trust – 42.3%
4. Surrey and Borders Partnership NHS Foundation Trust – 42.1%
5. Mersey Care NHS Foundation Trust – 32.7%<sup>90</sup>

### ***'Not functionally suitable' clinical space***

Another element of ERIC is the assessment of 'clinical space' deemed to be 'not functionally suitable' (defined as 'below an acceptable standard, or unacceptable in its present condition, or so below standard that nothing but a total rebuild will suffice').<sup>91</sup>

In 2019/20 out of 342 Mental Health (including specialist services) sites, five had 100% of its clinical space assessed as 'not functionally suitable' (around a third of the 16 across all site types in England), a further eight were deemed to be between 50 and 99% functionally unsuitable, 17 were between 25 and 49% and 11 were between 10% and 24%.

By comparison the numbers for general acute, out of 219 sites, were 0 at 100%, 19 at 50-99% (7.2%), 32 at 25-49% and 35 at 10-24% and for community hospitals, out of 222 sites, were 10 at 100%, 12 at 50-99% , 8 at 25-49% and 11 at 10-24%.<sup>92</sup>

Case studies are provided in Appendix 1.

## **Action 5: NHS trusts to clear the high and significant risk maintenance backlog in mental health and learning disability services**

The four categories of maintenance backlog are defined as below:

- High risk is defined as where repairs/replacement must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.



- Significant risk is defined as where repairs/replacement require priority management and expenditure in the short term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- Moderate risk is defined as where repairs/replacement require effective management and expenditure in the medium term through close monitoring so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- Low risk is defined as where repairs/replacement require to be addressed through agreed maintenance programmes or included in the later years of an Estates Strategy.<sup>93</sup>

Backlog is reported by both trust and site type.<sup>94</sup>

### ***Site type – mental health and learning disability***

For site type, in 2019/20, the total high-risk backlog across the three mental health and learning disability site types amounted to £16,170,598, which represents a 25.6% increase on 2018/19 (£12,879,428) and a 224.4% rise on just three years earlier (£4,984,567). While significant risk backlog declined by 1.5% in 2019/20 (£75,889,065) compared to 2018/19 (£77,041,125), it also remained 35.3% above the level of 2016/17 (£56,096,230).

### ***Trust type – mental health trusts***

When looking at this analysis by trust type, in 2019/20 the total high-risk backlog across mental health trusts amounted to £30.770m, which represents a 36.2% increase on 2018/19 (£22.593m) or 55.4% more than 2017/18 (£19.804m). There is a caveat that Midlands Partnership NHS Foundation Trust was formed in 2018/19 from a merger of a mental health trust (South Staffordshire and Shropshire Healthcare NHS Foundation Trust) and a community trust (Staffordshire and Stoke on Trent Partnership NHS Trust) and Gloucestershire Health and Care NHS Foundation Trust was formed in 2019/20 from a merger of a mental health trust (2Gether NHS Foundation Trust) and community trust (Gloucestershire Care Services NHS Trust). If the high-risk backlog from those trusts and forerunner organisations are excluded from the calculation, the increase in 2019/20 compared to the previous year is 46.0% (£26.425m is the revised total for 2019/20 and £18.102m for 2018/19) or 33.5% compared to 2017/18 (£19.800m).

Adopting the same approach to the significant risk backlog, the total in 2019/20 (£139.832m) is 14.7% up on 2018/19 (£121.915m) and 17.0% more than 2017/18 (£119.538m) if all mental health trusts are included. Alternatively if the merged trusts are excluded from the figures, the total in 2019/20 is £130.970m which is an increase of 12.4% on 2018/19 (£116.477m) and 13.5% on 2017/18 (£115.399m)<sup>95</sup>

It is not possible to completely separate infrastructure backlog pressures from capital investment, as if providers were to address their ageing estate through a rebuild programme, then this would also address the critical maintenance backlog. More than half of the high and significant risk backlog combined in mental health trusts is found in only seven trusts:

- West London NHS Trust – £19.534m, 11.45%
- South London and Maudsley NHS Foundation Trust – £17.532m, 10.28%
- Bradford District Care NHS Foundation Trust - £13.371m, 7.84%
- Dorset Healthcare NHS Foundation Trust – £9.789m, 5.74%
- Barnet, Enfield and Haringey Mental Health NHS Trust – £9.139m, 5.36%
- Midlands Partnership NHS Foundation Trust - £8.916m, 5.23%
- Kent and Medway NHS and Social Care Partnership Trust - £7.900m, 4.63%.<sup>96</sup>

Alternatively, if we look at mental health and learning disability sites, just four trusts are responsible for a majority of the high and significant risk backlog, with the first three all located in London:

- West London NHS Trust - £18.062m, 19.62%
- South London and Maudsley NHS Foundation Trust - £15.625m, 16.97%
- Barnet, Enfield and Haringey Mental Health NHS Trust - £7.603m, 8.26%
- Mersey Care NHS Foundation Trust - £5.863m, 6.37%<sup>97</sup>

## Action 6: DHSC to invest in digital improvements

### *Electronic patient records and interoperability*

Mental health services have been at the forefront of using electronic patient record (EPR) systems for many years. However, the potential benefits of modern software, apps and clinical informatics are not being realised. Currently available EPRs make recording overly time-consuming and difficult to use, with patients' stories and important clinical information often unrecognisably fragmented across multiple fields. Moreover, there is a need for greater interoperability between different recording systems. At present, if a patient moves residence to another (ICS/STP) area or is transferred from a mental health trust to an acute trust, there is generally no direct transfer of patient records – with obvious implications for interruptions in their care.

Interoperability must be achieved if the proposed Mental Health Act reforms are to be realised. At present the majority of Mental Health Act related activity is still carried out using paper-based systems, including forms for assessment, medication or leave. This means that information is often incomplete or inaccessible to patients and staff, so there is a greater risk of mistakes being made because of human error, and patients and carers are provided with less information. 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>98</sup>

There is also an important opportunity to improve patient centred care/empowered patients, through improving patient access to their records, where appropriate. At present, patients are put at a disadvantage by current outdated record systems which constrains their access to their own records, thereby hampering their ability to contribute to their care and care planning. This is despite mental health services being at the forefront of shared decision-making.

### *Clinical information systems*

Clinical information systems are also inadequate for clinicians' needs, resulting in considerable time in entering information and limited ability to extract the relevant information needed to monitor and manage the quality of care. Dashboards that provide clinicians with benchmarkable information about their caseload would be invaluable. Clinical interpretation of data not only benefits patients, but also enables clinicians to benchmark against their peers which helps to drive up quality. Yet, there is lack of access for mental health services to other services' information systems, preventing access to needed information such as CT scan imaging to clarify diagnoses.

Clinical administrative work has become a significant burden and focus for all mental health staff which significantly and negatively impacts on clinical quality, safety and productivity. This has been recognised by the CQC and Lord Carter's 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.<sup>99</sup> 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.

Against all this context, the recently announced What Good Looks Like programme of work, which will see Trusts and other NHS Organisations assessed against guidance to identify gaps and prioritise areas for investment and improvement, is promising. In addition to considering technology, this will look at the culture, the people, the skills and the processes that are required to support good digital and data transformation. The accompanying programme of work from 2021 to 2023 and onwards aims to fix many of the problems outlined above. This must be sufficiently funded and have the oversight and governance procedures needed to achieve its ambitions.

## Action 7: DHSC to establish a Mental Health Innovation Fund

Alongside the established national programmes to encourage and enhance digital provision of mental health services, the College is advocating for the establishment of a Mental Health Innovation Fund that would

enable industrial innovators to work with NHS clinicians on the development and implementation of a diverse range of solutions.

It is envisioned that funds would be allocated on a competitive basis in two phases for each project, with the initial phase facilitating research and assessment of technical feasibility and further funding then awarded for a smaller number of innovators in the second phase to develop and evaluate prototype solutions with their NHS partners. Successful initiatives would be made freely available to the National Health Service with the successful innovators then allowed to sell their developed solutions to other healthcare systems.

On the basis of each competitive process costing around £400,000 (with an assumption that 5-7 bids would be successful for the initial £10,000 funding in the first phase and then two would proceed to receive around £150-175,000 in the second phase, an annual fund of £12m would enable around 30 competitions to take place each year.

## Recommendations

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

1. At the 2021 CSR, the Government, DHSC and NHSE/I to provide a ring-fenced investment of an additional **£3bn** to mental health NHS trusts between 2022/23 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 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,
    - £535m 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 and with a commitment to deliver a further six mental health building and redevelopment schemes by 2030 (inclusive 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>100</sup>
    - £750m 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
    - £300m to reaffirm the commitment to complete the elimination of dormitory provision and replace with single en-suite rooms
    - £700m for new building and redevelopment schemes for community mental health facilities, including clinical and office space, and the essential improvements to digital infrastructure 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. This includes around £135m of capital investment to mental health trusts for IT infrastructure and an expansion of the Digital Aspirant programme to a further ten mental health trusts by 2024/25, underpinned by £65m of capital funding.

- £270m 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.
  - £90m of capital funding for drug and alcohol use disorder services to support the implementation of the Dame Carol Black Review<sup>101</sup>
  - £120m for Research and Development in Mental Health and Dementia
  - £37.5m for the first three years of a Mental Health Innovation Fund, enabling entrepreneurs to work with clinicians in partnership to deliver innovative schemes that would be available to the NHS free of charge.
- b. £204m to eradicate current significant and moderate risk maintenance backlog in mental health and learning disability sites/estates.
2. 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.
  3. Within the existing HIP programme or where investment is being made for a new or upgraded acute hospital, DHSC, NHSEI and local leaders to consider whether plans include sufficient space for integrated mental health and physical healthcare (liaison mental health services) to be delivered. This needs to be built into service design from the outset.
  4. DHSC, NHSE/I and NHSX to set up a new Mental Health Innovation Fund underpinned by £36m over three years.

## **OBJECTIVE 2: Ensuring our mental healthcare system can cope with demand: crisis resolution and future-proofing**

### **Context**

The NHS Long Term Plan included a commitment that mental health services would grow faster than the overall NHS budget – with a ring-fenced increase in investment worth at least £2.3bn a year by 2023/24. Prior to the pandemic, an ambitious programme of work had got underway to improve and transform mental health services in England. While there was a long way to go to achieve parity of esteem between mental health, learning disability and autism services and physical health services, investment had started to make a tangible difference.

When the COVID-19 pandemic struck, it quickly became apparent that diminishing service provision due to mental health services being required to close or reduce their services (for staff absence or redeployment reasons) was coinciding with rising levels of need. Clinicians started 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-19 psychosis. There were also lockdown-specific deteriorations in patients' mental health due to a lack of face-to-face contact and the impacts of hardship and isolation – such as those experiencing eating disorders.

As the pandemic has continued, data clearly indicates that some patients avoided seeking help for their mental health during the pandemic, particularly via A&E, primary care and child and adolescent mental health services (CAMHS) – exacerbating challenges of delivering FYFVMH/LTP targets. Areas which had seen pre-pandemic improvements such as perinatal and IAPT saw their progress towards targets derailed. While referrals are now generally at or above pre-pandemic levels (dependent on the service), there is a strong expectation that mental health referrals will continue to rise. Given that Covid-19 exacerbated existing health inequalities, the mental health impacts of the pandemic may also prove to impact those with existing risk factors the greatest.

The Government committed £500m in March 2021, as part of the Mental Health Recovery Action Plan. This provided an injection of emergency funding across a wide range of services and programme areas. This additional funding was critical and widely welcomed. Spending per head for 2020/21 in England was also 6.7% higher than the previous year, averaging £202.21.<sup>102</sup> A majority of STP areas – 23 out of 42 – spent over £200 (adjusted for need) compared to only 17 in 2019/20.<sup>103</sup> Nevertheless, service pressures remain acute across many areas. As such, the need to adequately resource and bolster the mental healthcare system (from promotion, prevention and treatment) to cope with demand is not yet resolved; further work is needed. The approach taken should ensure that programmes and services meet demand across the system, quickly and effectively supporting those with mild to moderate mental illness and preventing people from reaching crisis.

Modelling work has been undertaken by a number of organisations to try and ascertain the level of need/demand for mental health services resulting from the pandemic. Mental Health trusts and NHS Providers estimate that 8 million people are struggling with their mental health but unable to access care because they are not yet deemed to be unwell enough.<sup>104</sup> This is in addition to NHS England & NHS Improvement's estimate that there at least 1.5 million people that have either been accepted for or are eligible for care but yet to receive it.<sup>105</sup>

The Strategy Unit's modelling suggests that over the next three years, there may be 1.8m new presentations, recurrences or exacerbations of mental ill health across England as a direct or indirect result of the pandemic.<sup>106</sup> They have costed increased activity at around £3bn, taking more conservative estimate assuming a lower acuity of new patients, or up to £4bn assuming the case-mix of new patient needs would be the same as pre-covid case mix. Whilst these are huge sums, the Centre for Mental Health estimates far higher numbers for new or additional mental health support (up to 10.08 million people - 8.58 million

adults, 1.5 million children and young people)<sup>107</sup>, though they do not provide accompanying financial figures.

Beyond the impact the ongoing COVID-19 pandemic will have on demand for mental health services, services will grow to meet more unmet need, as per the Five Year Forward View for Mental Health and NHS LTP commitments. Demand will also continue increase naturally as the population grows. 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 England.<sup>108</sup> Mental illness remains one of the largest single causes of disability in England.<sup>109</sup>

More children and young people in the population indicates capacity will need to be increased for CAMHS, parenting programmes, self-harm, substance use disorder and criminal justice liaison services. Early diagnosis and support will also be needed for children and young people with neurodevelopmental disorders. 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.<sup>110</sup> While 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. The likely long-term growth in dementia incidence and prevalence across England is also substantial.<sup>111</sup> Focussing on care clusters rather than age groups is suggestive of further likely growth areas based on demographic changes alone (before Covid-19 impacts are taken into account): that of common mental health problems/mild non-psychotic disorders, as well as severe psychotic depression.<sup>112</sup> Our previous briefing considers this in more detail.<sup>113</sup>

The College has previously said that a reduction in the population in their 20s and 50s indicates 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. However, further scrutiny of modelling work will be needed to identify whether or not COVID-19-induced need will negate decreased population within these cohorts.

Overall, increased demand due to COVID-19 combined with anticipated population increases between 2018 and 2029 may mean that demand does not return to pre-pandemic levels. However, there are many actions that can be taken to help diminish population levels of mental health need, via public health approaches. Such preventative actions are essential to keeping people as mentally well as possible and limiting rising need for mental health services. This includes actions across a wide range of social determinants of health, notably including action to mitigate the climate and ecological emergency.

Finally, it is important to note that spending on mental health services must keep up with any growth in other areas. This is critical, both in principle – to uphold parity and not risk a return to the underinvestment and under prioritisation of the past – but also in order to meet on existing policy commitment: the Mental Health Investment Standard. The MHIS, set by NHS England, requires all CCGs in England to increase their spending on mental health services (excluding learning disability and dementia services) by a greater proportion than their overall increase in budget allocation each year. National budgetary allocations must enable CCGs to meet this Standard.

### **Action 1: Mental health providers able to meet increased demand for NHS mental healthcare services**

The mental health consequences of COVID-19 are widely acknowledged and reflected in service level data. We are facing not just a backlog of existing patients who did not access care during the peak of the pandemic, but also an increase in the number of patients requiring care. Both groups are now presenting with greater acuity and complexity.

Eating disorder services for children and young people have seen particularly significant rises. The most recent data showed there was a 160% increase in completed urgent pathways in Q1 2021/22 compared to the

same period last year (852 compared to 328) and an almost fourfold increase in urgent cases waiting for treatment (207 compared to 56). For routine cases, the increases were 93% for completed pathways (2,600 compared to 1,347) and 315% waiting for treatment (1,832 compared to 441) respectively.

Access and waiting time standards for children and young people's eating disorder services state that 95% of children and young people who are referred should receive NICE-approved treatment within 1 week for urgent and 4 weeks for non-urgent cases. There has been a marked decline in performance against this target during the pandemic. In the period between April and June 2021, only 61.0% of urgent cases commenced treatment within one week, compared with 87.8% in the corresponding period in 2020/21 when performance was at its best level to date. Similarly, for routine cases 72.7% of children and young people with a routine case commenced treatment within four weeks between April and June 2021, which was 14.1 percentage points lower than the same period in the previous year (86.8%). Although disappointing, this data must be read in the context of the significant growth in demand.<sup>114</sup>

After briefly returning to closer to pre-pandemic levels in January and February of this year, referrals to children and young people's mental health services (0-18 year olds) have once again seen very significant increases in April (85% up on April 2019), May (99% up on May 2019) and June (102% up on June 2019). Over the last six months of 2020/21, there were 59% more such referrals compared to same period in 2019/20 (332,293 compared to 209,291).<sup>115</sup> Due to the huge rises in referrals a reduced proportion of CYP are starting treatment, and more are on waiting lists.

Access to perinatal mental health services had been a 'good news story' for a number of years, with efforts under the Five Year Forward View for Mental Health (FYFVMH) seeing an additional 20,000 women accessing perinatal services each year by 2019/20. The NHS Long Term Plan's Implementation Plan confirmed an ambition to see 47,000 women accessing services by 2020/21, a further 5,000 on top of the final FYFVMH target. This would have been equivalent to the number of women responsible for 7.1% of total births each year. By March 2021, however, only 4.8% of birthing women had accessed perinatal services in the preceding twelve months, with no English region attaining the level expected.<sup>116</sup> So, during the first year of the pandemic around 15,500 fewer women accessed specialist perinatal mental health services than expected. Given that maternal mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family if left untreated, this missing 15,500 could result in a higher level of need for access to mental health services (and wider services) amongst this cohort in future.

In relation to adult secondary mental health services, 153,000 over-18s are estimated to have missed out on referral to adult secondary mental health treatment in 2020/21 (based on year-on-year trends) without even taking into account the likely increase in need because of the pandemic.<sup>117</sup> This highlights the need for more detailed modelling towards a better understanding of the unmet need.

In addition to the official data evidencing a significant rise in demand for services, there is also anecdotal evidence of similar increases in areas in which official data is not gathered/published.

Firstly, there have been reports of increasing referrals to liaison services from acute hospitals for delirium, COVID-related mood & anxiety disorders (including PTSD, non-delirium COVID-19 psychosis and for patients having long hospital stays or who have become deconditioned (loss of functional abilities) during a hospital stay).

Secondly, there have been reports of lockdown-specific deteriorations in patients' mental health due to a lack of face-to-face contact, such as those with psychosis, adult eating disorders and obsessive compulsive disorder, as well as for people with depression prolonged by economic hardships and/or loneliness and addictions. Thirdly, there are people who have had longer durations of untreated psychosis as they have presented later and sicker. There are also anecdotal reports from our members of people presenting for the first time with depression and psychosis, only after attempting suicide.



NHSE/I committed to maintain their investment guarantee for mental health, learning disability and autism services during the COVID-19 pandemic.<sup>118</sup> Funding for the expansion of mental health services did indeed increase in 2020/21, though levels of demand clearly outstripped what had been expected and planned for, leaving greater numbers needed support. Without further funding over and above the investment guarantee, mental health services will struggle to recover.

## Recommendations

1. Government to commit to maintaining and building upon improvements from the Mental Health Recovery Plan, enabling:
  - restoration of services to trajectories outlined in NHSE Mental Health Implementation Plan
  - response to demand for mental health services arising from COVID-19 pandemic
  - the introduction of waiting time standards as per the clinical review of standards

This commitment should be underpinned by an additional £1bn in 2022/23, £1.5bn in 2023/24, and £2.4bn in 2024/5, to maintain progress beyond the initial Long Term Plan period by continuing to address the care gap.

2. In line with recommendations of the Commission on Acute Adult Psychiatric Care in England, NHSE/I to establish better ways to monitor and respond to demand and capacity within mental health services.

## Action 2: Local authorities to respond to increasing levels of mental distress and co-morbid physical health problems in the population due to COVID-19

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.

### *Worsening mental health*

The Office for National Statistics (ONS) indicate that the number of people reporting high levels of anxiety has sharply elevated during the COVID-19 pandemic, with loneliness, marital status, sex, disability, whether someone feels safe at home, and work being the factors most strongly associated with high anxiety.<sup>119</sup> Similarly, the Centre for Mental Health note that those who face an especially high risk to their mental health include people facing violence and abuse, people with long-term health conditions, and people from BAME communities.<sup>120</sup>

Given the rising tide of referrals to mental health services outlined above, we share with the Mental Health Policy group<sup>121</sup> the view that investment in prevention and promotion is critical to keep more people well, and thus prevent clinical mental health services being overwhelmed, both over the shorter and longer term. The evidence is clear that it is the places and circumstances in which people are born, grow, study, live and work that have a powerful influence on their mental health. A successful future for public health will require improved and sustained investment across many areas of government spending not formally termed either 'public health' or 'mental health' as these have some of the greatest impacts on mental health. A commitment to a national plan for public mental health must be supported by guaranteed funding that matches the rate of budget increase of the NHS, with a proportion earmarked for public mental health. At a local level the Public Health Grant to local authorities is vital for achieving good mental health, but without adequate funding local authorities are being held back from fulfilling their potential to protect the public's mental health.

Alongside the Mental Health Policy Group, we want the public mental health element of the Public Health Grant to be focused on building resilience in communities. But there should also be funding for tackling the



bigger factors that affect mental health. This could include targeted funds for partnership working at a local place-based level, with coproduction at its centre, so that citizens shape the solutions for their communities, and are part of commissioning systems and structures such as ICS Boards. The Prevention Stimulus Fund is a good example of targeted funding for working with the most deprived and marginalised communities at greatest risk of poor mental health to provide early support before people require intensive clinical services.

More broadly, local authorities also manage assets vital to the public's mental health, such as housing and planning functions, elements of education, children's and adult social care services, the maintenance of parks and open spaces, provision of libraries, children's centres and youth services. All of these have the potential either to enhance and protect people's mental health, or – including in their absence - to diminish and harm it. Yet their important role in public mental health is under great pressure following too many years of austerity cuts.

On children and young people's mental health in particular, we note that Covid-19 and the related national lockdowns has coincided with evidence of a sharp increase in mental health needs, as evidenced by CAMHS and CYP ED service waiting list expansion. While research will be needed to prove causality, it seems likely that curtailed access to many of the protective factors that help keep young people and their families well will have directly impacted on their wellbeing. We therefore echo Mental Health Policy Group in noting the role of Mental Health Support Teams (MHSTs), and the commitment made in 2020 to expand them further and faster than the timescales set out in the Long Term Plan given the acknowledged increase in mental health needs amongst children and young people. The early evaluation of the MHST trailblazer sites shows some positive outcomes, but as to expected from innovative services, there is also learning from pilot sites that can be built on for the next phase. The evaluation highlighted that MHSTs were not always able to meet some of the most urgent and unmet mental health needs and retention of staff was a challenge. Increased investment for the development of staff, which includes attachment and trauma-informed training would help the MHST better meet the needs of children and young people and improve staff retention. It is important that rigorous and ongoing evaluation of MHSTs is completed so that any gaps can be addressed before full rollout is considered.

Every Mind Matters is an important tool to allow people – including children and young people - to manage their mental wellbeing. Alongside Mental Health Policy Group, we welcome the confirmation of the full 2021/22 budget for children and young people's Every Mind Matters. However only 50% of the adult budget for 21/22 has been confirmed. MHPG want to see a long-term commitment to fully fund both adult and children and young people's Every Mind Matters platforms.

In relation to babies and toddlers (the important first 1000 days of life) there is concern that the lack of services and supports – contributing to a uniquely difficult time to be pregnant, give birth, or be a home with a baby or toddler - may cause a 'long shadow'.<sup>122</sup> If parents do not have the physical or emotional capacity to provide nurturing care, then crises such as the COVID-19 pandemic can have potentially significant and lasting impact on babies' development, with knock on impacts on later learning, earning, mental and physical health.<sup>123</sup> Health visiting teams, funded through the Public Health Grant, therefore have an ever more important role in supporting infants, toddlers, and their care givers, and identifying those at risk. It is therefore concerning that after peaking in October 2015 (10,309 full-time equivalent), the number of health visitors in NHS community health services have declined to only 6,422 FTE in the latest available data for May 2021 (36.5% lower than the same point in 2015).<sup>124</sup> To perform most effectively, health visitors should be embedded within specialised parent-infant relationship teams: multidisciplinary teams with the specialist skills required to work with babies and their families where there are severe, complex and persistent problems in early parent-infant relationships which jeopardise babies' mental health and development.

Following the reorganisation of Public Health England, it recently became known that public mental health will move into the Office for Health Promotion and Disparities (OHPD). We hope this change will prove to be positive for mental health promotion efforts, and would like to see a plan to improve public mental health developed.

### ***Worsening physical health***

Poor mental health is associated with other priority public health challenges such as obesity<sup>125</sup>, lack of regular exercise<sup>126</sup>, alcohol use disorders<sup>127</sup> and smoking.<sup>128</sup>

People living with a mental illness are more likely to die prematurely than the general population. 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. Prior to this, the gap had only reduced marginally over the preceding 7–8 years.<sup>129</sup> 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. Many of these ‘excess’ 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 and community falls prevention).

People who are more vulnerable to developing a severe illness and dying with COVID-19 include older people, people living in more deprived areas, those from BAME communities, and people with some physical health conditions.<sup>130</sup> Excess deaths due to COVID-19 have been linked with inequalities, being from a BAME background, obesity and smoking and there is likely to have been preventable deaths from physical health conditions that are overrepresented within people with severe mental illnesses. We should expect therefore, that these groups may also experience some impact on their mental health as a result of the pandemic.

Given that people with severe mental illness have a higher prevalence of a number of physical health conditions, even with factors such as deprivation, age and sex taken into account, the programme of Physical Health Checks for people living with severe mental illness is designed to identify possible physical health issues early and allow patients and their clinicians to take appropriate steps to minimise risk moving forward.

The NHS Long Term Plan established a commitment for 390,000 people to receive a full annual Physical Health Check, with an expectation for 60% of people on GP Practice SMI registers to receive a check. However, in March 2020, the percentage of people who had received a check in the preceding year stood at 36%. This number has fallen further during the COVID-19 pandemic, reaching a low of 21.6% in the year to December 2020.<sup>131</sup>

Together with Mental Health Policy Group, we welcomed the Government’s recognition of this challenge in the 2020-2021 winter plan and COVID-19 Mental Health Recovery Action Plan, supported respectively by £5m and £14m of investment to support the physical health of people with severe mental illness. This has supported the introduction of outreach schemes supporting people to receive support for the physical health, including Physical Health Checks.

Significant and promising progress has been made towards establishing and beginning delivery of physical health outreach programmes across the country, and the impact of this work is just beginning to be reflected in advancement towards the 60% target in several CCG areas. NHS England statistics show that the percentage of eligible people who had received a full Physical Health Check in the previous year increased by over 10% in 18 CCG areas in just one quarter (Q4 of 2020/21) despite the country being in lockdown conditions during this period.

Within the new command paper outlining plans for health and social care,<sup>132</sup> the government has rightly emphasised the importance of prevention and the role of ongoing Health Checks in supporting individuals to be healthier and access the right treatments. As we emerge from restrictions, it is more crucial than ever that people with SMI are supported to deal with physical health issues that may have emerged in the backdrop of the pandemic. Outreach around physical health driven by the VCSE sector will play a vital role in supporting GPs to deliver key commitments around physical health and SMI as primary care recovers from

the pandemic.

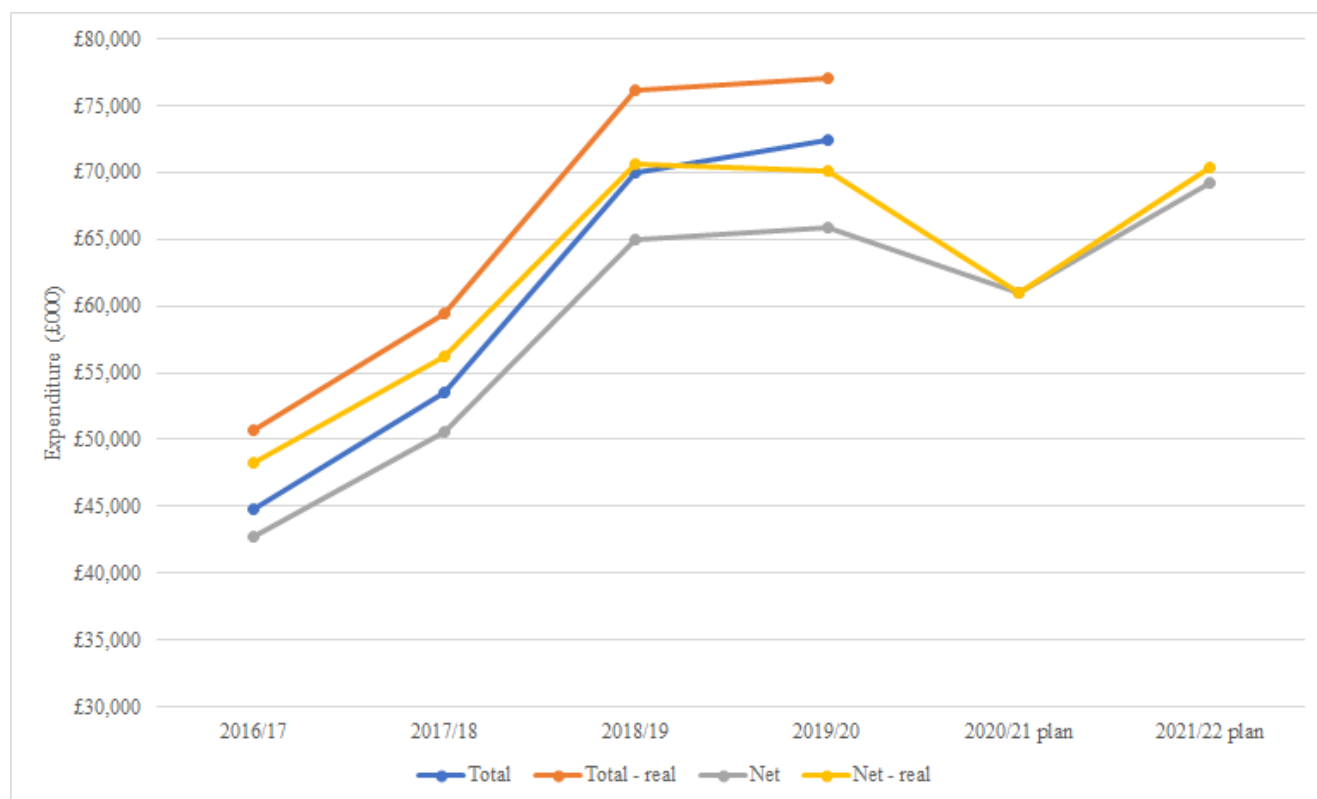
### ***Funding for public mental health***

In March 2021, it was confirmed that the Public Health Grant for 2021/22 would increase by only £45m in cash terms compared to the previous year.<sup>133</sup> For public mental health funding specifically, local authorities have only been required to report public mental health expenditure since the 2016/17 financial year. A Freedom of Information request by Mind determined that the proportion of public health budgets spent on mental health declined year-on-year between 2013/14 and 2015/16, from 1.4% to 0.7%.<sup>134</sup>

The situation had initially improved since reporting commenced when looking at the outturn total expenditure, with the amount increasing by 51.9% after adjusting for inflation (2020/21 prices) between 2016/17 (£50.682m) and 2019/20 (£76.987m). There are however concerns about subsequent planned net current expenditure figures, which at £60.947m in 2020/21 and £70.405m in 2021/22 after adjusting for inflation would be a 13.7% and 0.3% below the investment in 2018/19 (£70.631m) if realised in the final figures.

As a percentage of the public health expenditure overall, the percentage of total expenditure has peaked at 2.1% in 2019/20 or 2.0% in terms of net current expenditure in 2019/20 and again in the planned spending in 2021/22 (after COVID-related expenditure is excluded for purposes of direct comparison).<sup>135</sup>

***Chart 3. Public mental health investment by local authorities in England, total and net current expenditure in cash and real terms (2020/21 prices), 2016/17 to 2021/22***



While this briefing does not attempt to cover the funding commitments of other government departments (with exception of the relevant mental health services provided by the Department for Levelling Up, Housing and Communities), we acknowledge that issues surrounding housing, benefits, employment and education, for instance, are inherently linked to people's mental health. Therefore, there needs to be a continued investment in mental health support in schools which can prevent more children and adolescents becoming unwell, good quality housing that can reduce the risks of mental health problems, a roll out of programmes that boost employment, and support for programmes that address systemic inequalities which could reduce the risk of mental illness (to name a few).

## Recommendations

### *Funding*

1. At the 2021 CSR, the Government and DHSC to commit to increase the Public Health Grant budget<sup>136</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, this should enable local authorities to ring-fence at least 4% of total public health expenditure for public mental health spending, equating to a rise of 87% or £67m compared to 2019/20 figures as the start of sustained and growing investment in this area.

This funding should be linked to the JSNA for each locality and relevant local strategies. It should also align with the growth in the workforce of public mental health professionals and those within voluntary, community and social enterprise organisations.

2. Together with Mental Health Policy Group, we're asking for £14m per annum to allow for the continuation of physical health outreach programmes, ensuring continued progress towards the NHS Long Term Plan target. ICSs must also be encouraged and supported to use this outreach funding. This should form part of the investment package to maintain improvements from the Mental Health Recovery Plan as outlined under Action 1, above.
3. Together mental Health Policy Group, we're asking for the £15m Prevention Stimulus Fund allocated in the COVID-19 mental health and wellbeing recovery action plan to be continued, sustained and expanded into a long-term Promotion and Prevention Fund. This funding would enable better commissioning and implementing of new services in the most deprived local authorities, helping stimulate and boost prevention and early intervention services and reduce health inequalities.

### **Action 3: Local authorities and the NHS to meet increased demand for drug and alcohol use disorder services**

Public Health England have continued to track the prevalence of 'harmful drinking' (Alcohol Use Disorders Identification Test survey scores of 8 or more) throughout the pandemic. In the three months to June 2020 the rate reached a peak of 18.7% compared to 12.4% in the three months to February. This would represent 2.88 million further people aged 16 and above drinking at harmful levels if extrapolated to the full population in England.<sup>137</sup>

The latest Adult Psychiatric Morbidity Survey confirmed that 16.6% of adults drank at hazardous levels (AUDIT scores of 8 to 15), 1.9% were harmful or mildly dependent drinkers (AUDIT scores of 16 to 19) and 1.2% were probably dependent drinkers (AUDIT scores of 20 or more). As with previous years, men were more likely than women to drink at hazardous levels and above. Most adults drank at lower risk levels (57.5%) or did not drink at all (22.8%).<sup>138</sup>

The survey also identified that 3.1% of adults showed signs of dependence on drugs, including 2.3% who showed signs of dependence on cannabis only and 0.8% with signs of dependence on other drugs (with or without cannabis dependence as well). After increases in the 1990s, the overall rate has remained stable since 2000.<sup>139</sup>

COVID-19 is likely to have a worse effect on the health of people who use alcohol or drugs.<sup>140</sup> People living with an alcohol use disorder are more likely to develop serious complications, such as atypical pneumonia and acute respiratory distress syndrome if they contract COVID-19.<sup>141</sup> Similarly, people who inject drugs are more likely to get certain viral infections and cancers, which weaken their immune system. Recreational drug users are likely to consume drugs in social settings and engage in behaviour which increases their risk of

exposure to COVID-19. They can also weaken their immune systems by losing sleep, drinking alcohol and smoking tobacco or cannabis while taking recreational drugs. Drugs such as heroin, methadone and benzodiazepines can make patients more vulnerable to the damage done by COVID-19.<sup>142</sup>

The recently published Dame Carol Black independent review of drugs: phase two report sets out a way forward for drug treatment and recovery, providing 32 recommendations on the way forward. The report starkly makes the case that “Government faces an unavoidable choice: invest in tackling the problem or keep paying for the consequences.”<sup>143</sup> We welcomed this report and its call to increase investment in addiction services by an additional £552m ringfenced funding per year, to begin to undo the decade of cuts, to enable local communities to improve the quality and access to addiction treatment and support.

Also important to note is the decline in specialist clinicians leading addictions services. The Royal College of Psychiatrists’ 2020 addictions workforce report found a 58% fall in the number of higher trainee places, with five regions in England having no opportunities for such training. to drive up the quality of treatment offered, as well as train the wider health and social workforce to ensure people with addictions are offered the help they need.<sup>144</sup> Fewer trainees now will result in fewer specialists in the future. So unless urgent action is taken, addiction psychiatry is at a very real risk of being wiped out in a decade.

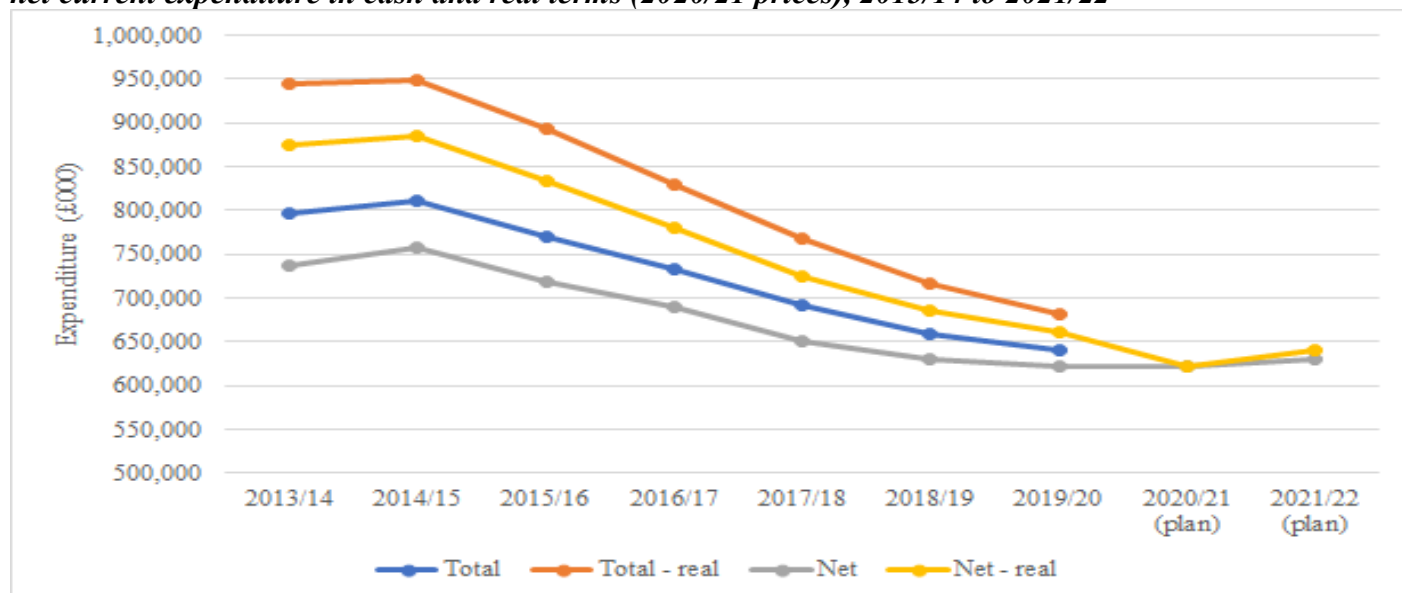
### ***Substance use disorder services – adults***

Total expenditure for adult substance use disorder services in 2019/20 (£682.087m) was 27.9% below the level of six years earlier (£945.738m) after adjusting for inflation. Alternatively, if the lens is turned on to net current expenditure the reduction in spending is 26.8% between 2013/14 (£874.476m) and the planned level for 2021/22 (£640.430m).

The spending data for drug and alcohol use disorder services is reported on separately by local authorities but have been combined for this report to reflect that such services tend to be commissioned together. We have also noted the concerns expressed by the Advisory Council on the Misuse of Drugs<sup>145</sup> among others about the consistency and reliability of the reported data, but it does nevertheless still confirm substantial reductions in investment.

These spending cuts have resulted in substance use disorder services for adults receiving a declining proportion of public health expenditure, whether this is based on total expenditure (from 29.9% in 2013/14 to 19.0% in 2019/20) or net current expenditure (from 29.4% in 2013/14 to 18.4% in 2021/22 based on reported planned spend, again after excluding COVID-related public health spend for direct comparison).<sup>146</sup>

***Chart 4. Spending by local authorities in England on substance use disorder services for adults, total and net current expenditure in cash and real terms (2020/21 prices), 2013/14 to 2021/22***

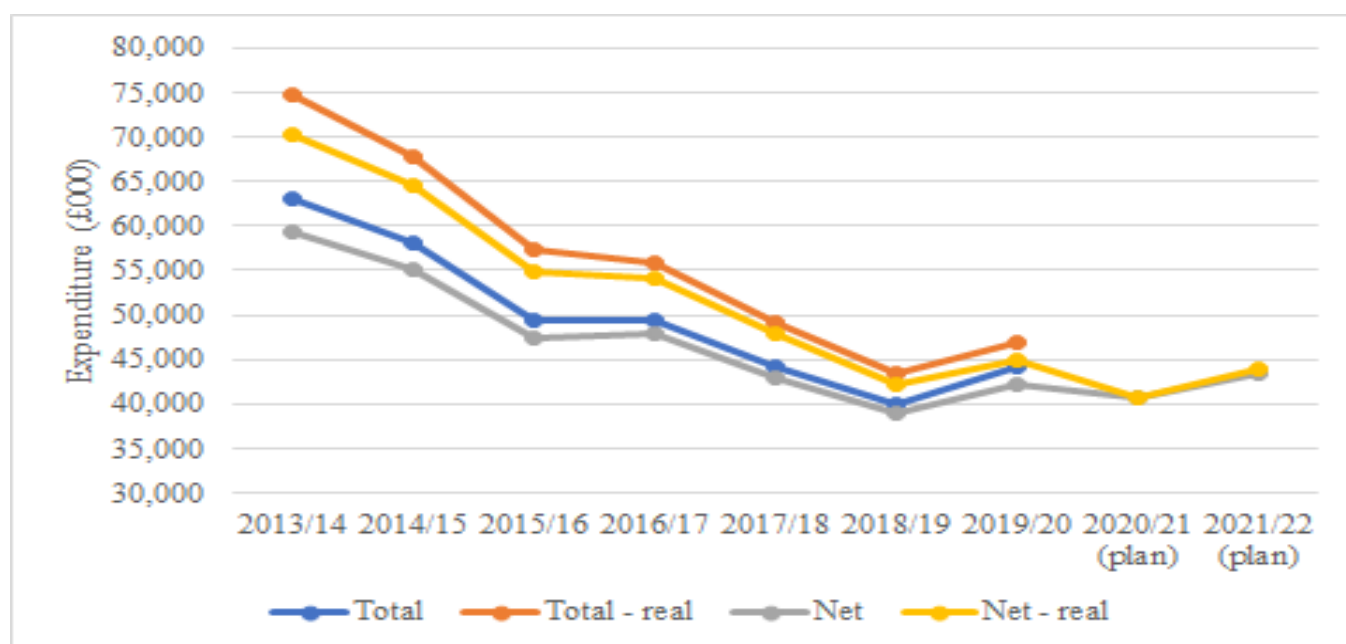


### ***Substance use disorders – specialist services for children and young people***

Expenditure is available from 2013/14 onwards following the transfer of public health services to local authorities. Total expenditure in 2019/20 (£46.919m) was down 37.1% compared to the level of five years earlier (£74.620m) after adjusting for inflation. Alternatively, if the comparison is based on net current expenditure the decrease in spending is 37.3% between 2013/14 (£70.337m) and the planned level for 2021/22 (£44.067m).

These spending cuts have resulted in specialist drug and alcohol use disorder services for children and young people under the age of 18 receiving a declining proportion of public health expenditure, whether this is based on total expenditure (from 2.4% in 2013/14 to 1.2% in 2019/20) or net current expenditure (from 2.4% in 2013/14 to 1.3% in 2021/22 based on reported planned spend excluding COVID-related expenditure for purposes of direct comparison).

**Chart 5. Spending by local authorities in England on specialist drug and alcohol use disorder services for children and young people, total and net current expenditure in cash and real terms (2020/21 prices), 2013/14 to 2021/22**



It is also worth noting anecdotal reports of increasing numbers of people presenting with behavioural addictions, such as gambling. Specialist face-to-face NHS treatment for gambling addiction was previously only available in London but is now being made available across the country as part of the LTP. As such, funding for NHS gambling services is currently provided by NHSE/I and not by local authorities.

### **Recommendations**

1. Government to commit the investment advocated by Dame Carol Black in her recent independent report on drugs<sup>147</sup> to restore funding for substance use disorders to a comparable share of public health spending to that of 2013/14. This would provide £396m additional investment to services a year by the end of the SR period or £550m when fully implemented.
2. DHSC to allocate £90m of capital funding for drug and alcohol use disorder services by 2024/25 to support implementation of the Dame Carol Black review with new facilities and estate.
3. DHSC and the Department for Levelling Up, Housing and Communities to review the commissioning of addiction services, including potential service models, in light of the independent



review of drugs by Dame Carol Black. The College endorses Dame Carol's call to improve commissioning standards and move towards integrated commissioning.

## **Action 4: Meeting mental health social care needs**

Like many health services, mental health is intrinsically linked to social care. It 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. In turn, this is putting extra pressure on individuals, families and the NHS.

There are three main statutory frameworks relevant to mental health for adults.<sup>148</sup> These include:

### **Mental Health Act:**

- Provide section 117 aftercare
- Employ Approved Mental Health Professionals (AMHPs)
- Identify and appoint Nearest Relative
- Provide statutory Independent Mental Health Advocacy (IMHA)

### **Mental Capacity Act:**

- Deprivation of Liberty Standards
- Employ Best Interest Assessors
- Provide statutory advocacy

### **Care Act:**

- Provide social work services and social work counselling
- Assess need and eligibility for community care
- Assess needs of carers
- Arrange personal budgets
- Advocacy

Of these areas, Section 117 is particularly important to discharge funding. Section 117 aftercare is a legal duty to provide after care services for individuals who have been detained under the Mental Health Act, once they are discharged from hospital. Aftercare services are intended to meet a need that arises from or relates to a person's mental health problem and reduces the risk of their mental condition getting worse. It can include healthcare, social care and employment services, supported accommodation and services to meet social, cultural and spiritual needs.<sup>149</sup> Difficulty in accessing appropriate post-discharge aftercare remains a major issue that impacts patients, bed availability and budgets. Funding for section 117 aftercare is therefore necessary to reduce delayed discharges.

Alongside Mental Health Policy Group we welcomed the £87m provided by the COVID-19 mental health and wellbeing recovery action plan to provide additional support for those leaving hospital, such as temporary accommodation or care at home. This funding has been critical to help address a growing issue of high levels of bed occupancy, and will continue to be needed to alleviate bed pressures.

On 7<sup>th</sup> September 2021 the Government announced a reform of social care<sup>150</sup>, based on recommendations put forward by the Dilnot Commission in 2011. The reform – and accompanying funding package – introduces a cap on total lifetime care costs from 2023 and an increased asset threshold for help with the costs of care. It will apply to people of all ages, including those living with severe mental illness. Many people severely affected by mental illness are unlikely to have assets that meet this threshold, and thus will have their costs covered by the state. This is welcome.

However, some of the problems with the current social care system remain. This funding does not provide the stability that stretched social care providers need, or address the lack of funding that means that local authorities are often unable to provide adequate care to all people living with mental illness that need this vital help.

Without investment in mental health social care services in particular, estimated at £1.1bn per annum by 2030/31<sup>151</sup>, significant pressure will continue to be placed on NHS services, and delivery of some of the Community Mental Health Framework (CMHF) could be jeopardised. Mental health social care is also required to ensure the provision of the services that local authorities have a duty to provide under the Care Act 2014, Mental Health Act and Mental Capacity Act, including community preventative support, social workers and care coordinators, employment support, supported living/housing, crisis services, advocacy services, continuity of support for those discharged from hospital, welfare rights, information, debt and money advice, and specific carers support reflecting the unique needs of carers of people with severe mental illness.

During the recent social care announcements, the Secretary of State for Health and Social Care stated that a portion of the £0.5bn allocated to support the social care workforce would go towards ensuring unpaid carers receive “more support, advice and respite.”<sup>152</sup> ADASS’s Autumn survey for 2020 reported an 11% increase in the proportion of individuals presenting with need to local authorities as a result of carer breakdown, sickness and unavailability between June and October/November 2020.<sup>153</sup> Investment in specialist carers support and wellbeing services is vital to protect carers’ own health and stop the charge of carer burnout.

### ***Social care – spending on mental health support for adults (18-64)***

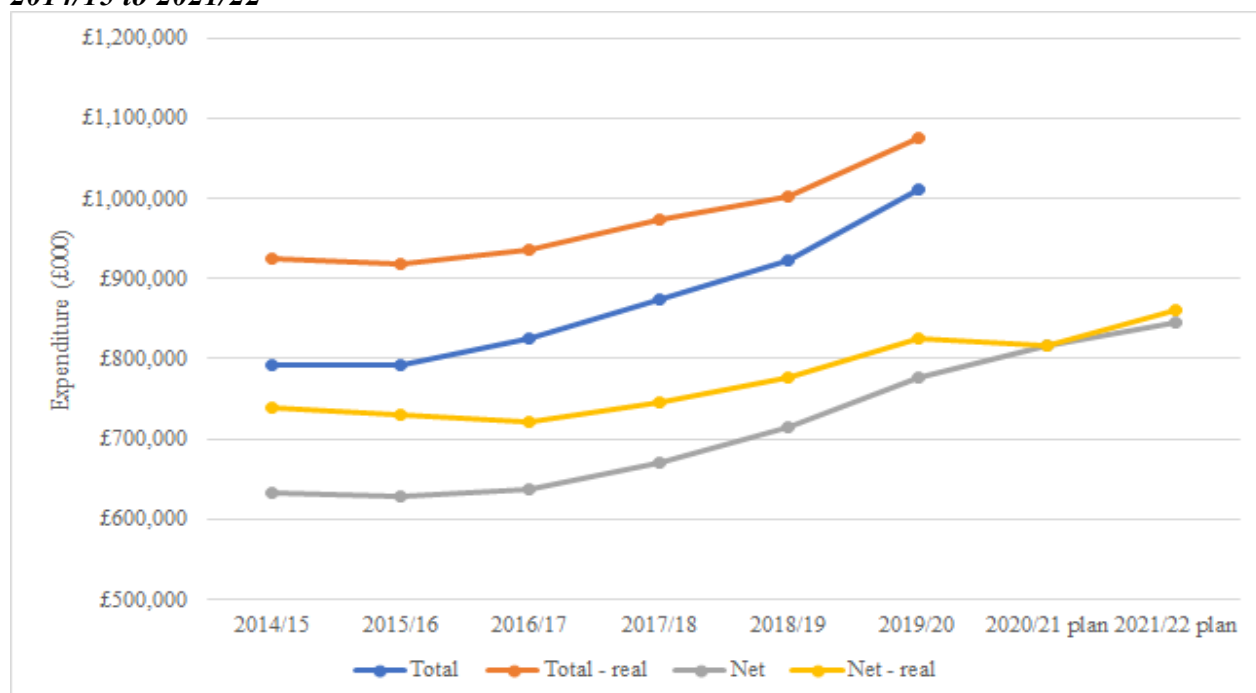
The reporting of expenditure on social care services fundamentally changed from 2014/15 onwards so previous data is not comparable (total expenditure by local authorities on ‘adults aged under 65 with mental health needs’ amounted to £1,336m in 2013/14).

Across the period of available data, the total expenditure peaked in real terms in 2019/20 (the most recent available year, £1,074,735m) and was 16.1% up on five years earlier after adjusting for inflation (£925.677m). Planned net current expenditure in 2021/22 (£860.064m) was 16.4% above the level of seven years earlier (£739.142m) in real terms after a period of relatively flat funding between 2014/15 and 2017/18 inclusive, although the latest planned spending data for 2020/21 was also showing a real terms decline compared to the previous year.

Both of these increases are above the real terms increases for adult social care funding overall across the same period – 9.6% for total expenditure between 2014/15 and 2019/20 and 11.7% for net current expenditure between 2014/15 and 2021/22.



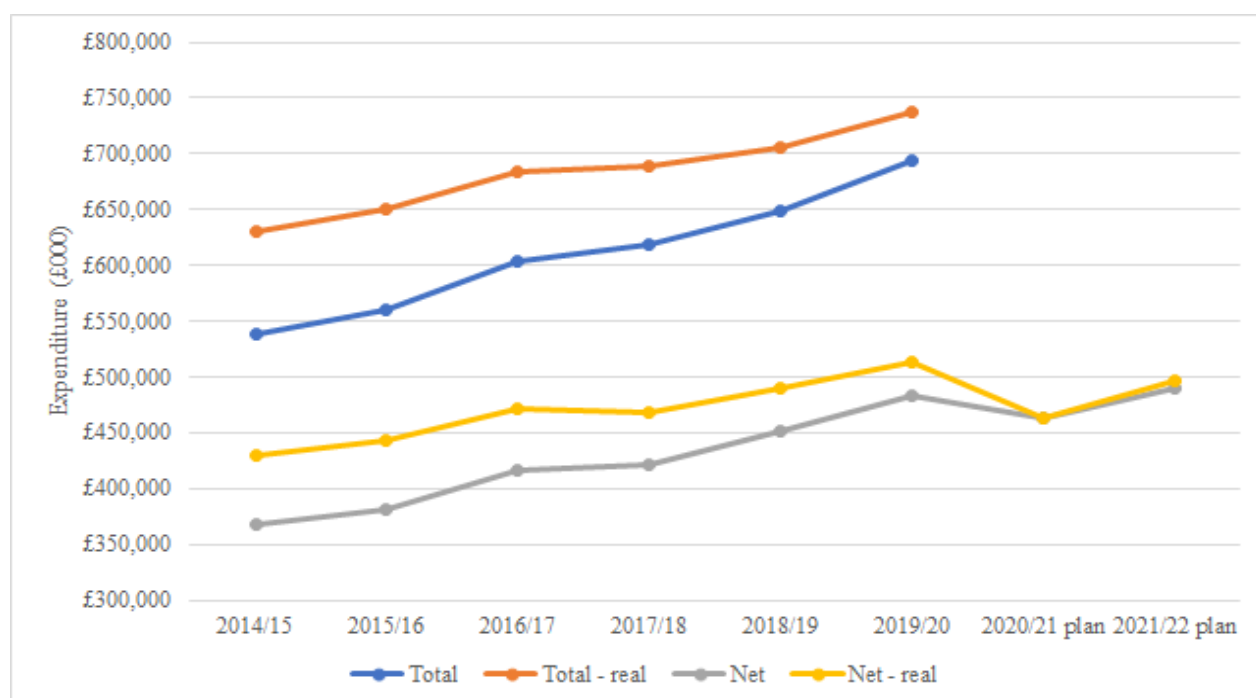
**Chart 6. Social care spending by local authorities in England on mental health support for working age adults (18-64 years old), total and net current expenditure in cash and real terms (2020/21 prices), 2014/15 to 2021/22**



### ***Social care – spending on mental health support for older adults (65+)***

Across the period of available data, total expenditure peaked in real terms in 2019/20 (£737.399m) and was 17.1% up on five years earlier after adjusting for inflation (£629.870m), however growth was slower between 2016/17 and 2018/19 (3.1% over the period). While planned net current expenditure in 2021/22 (£497.427m) is 7.5% above the latest level of planned spend for 2020/21 after inflation, it should also be noted that the latest amount is also equivalent to a real terms cut of 3.0% on 2019/20 (£512.969m).

**Chart 7. Social care spending by local authorities in England on mental health support for older adults (65+ years old), total and net current expenditure in cash and real terms (2020/21 prices), 2014/15 to 2021/22**



## *Social care – spending on mental health support for children and young people*

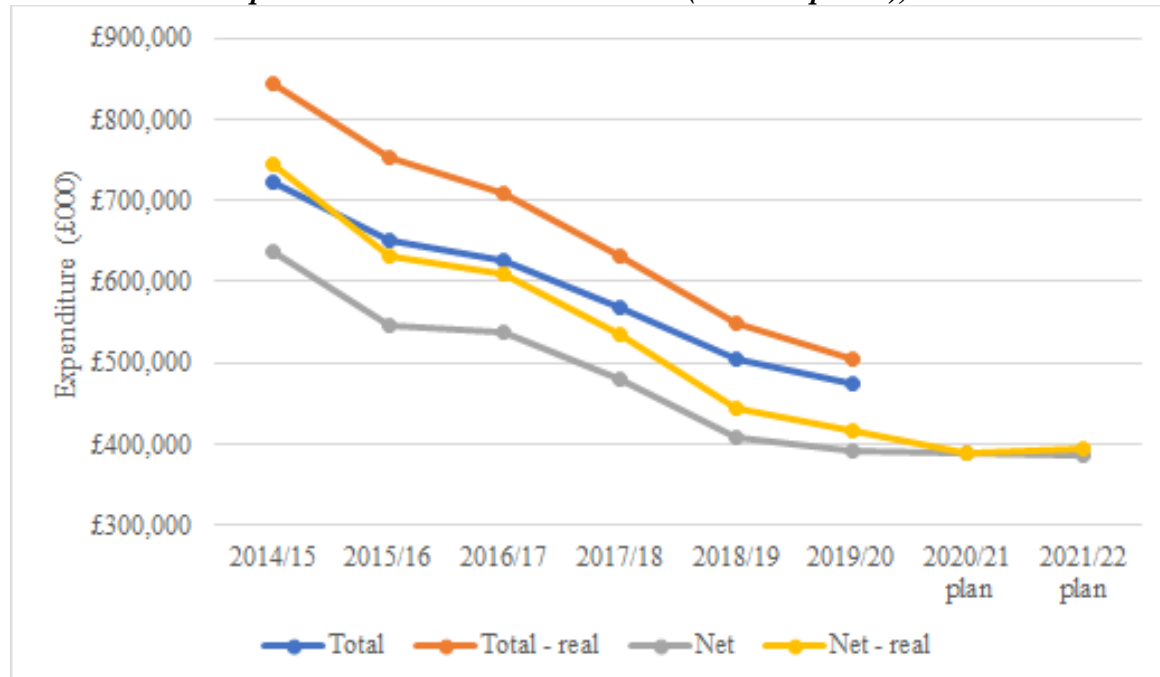
There is a lack of social care support for children and young people. The disinvestment in local authority funded services has led to closures of Sure Start centres, and a lack of support for children and young people with a neuro-disability, which ultimately results in more children and young people presenting to NHS mental health services in crisis. In May 2021, there were 943 emergency and 2,040 urgent referrals to crisis care teams involving under-18s, compared to 437 and 1,033 in May 2020 (116% and 97% increases respectively) or 645 and 1,220 in May 2019 (46% and 67% increases respectively).<sup>154</sup> There is also a clear issue with transitions for looked after children in particular as they turn 18 and subsequently lose support. All of these issues contribute to poor mental and physical health.

While data is not collected for mental health spending for children and young people by the Department for Levelling Up, Housing and Communities, the disinvestment in crucial services is evident from the charts below.

Spending on Sure Start and early years services has only been reported by the Department for Levelling Up, Housing and Communities and its forerunner departments since 2014/15. Total expenditure has fallen by 40.1% between 2014/15 (£844.294m) and 2019/20 (£505.507m) after adjusting for inflation. Alternatively, if looking at net current expenditure, the decline in real terms has been 47.2% between 2014/15 (£745.181m) and the planned amount for 2021/22 (£393.347m).

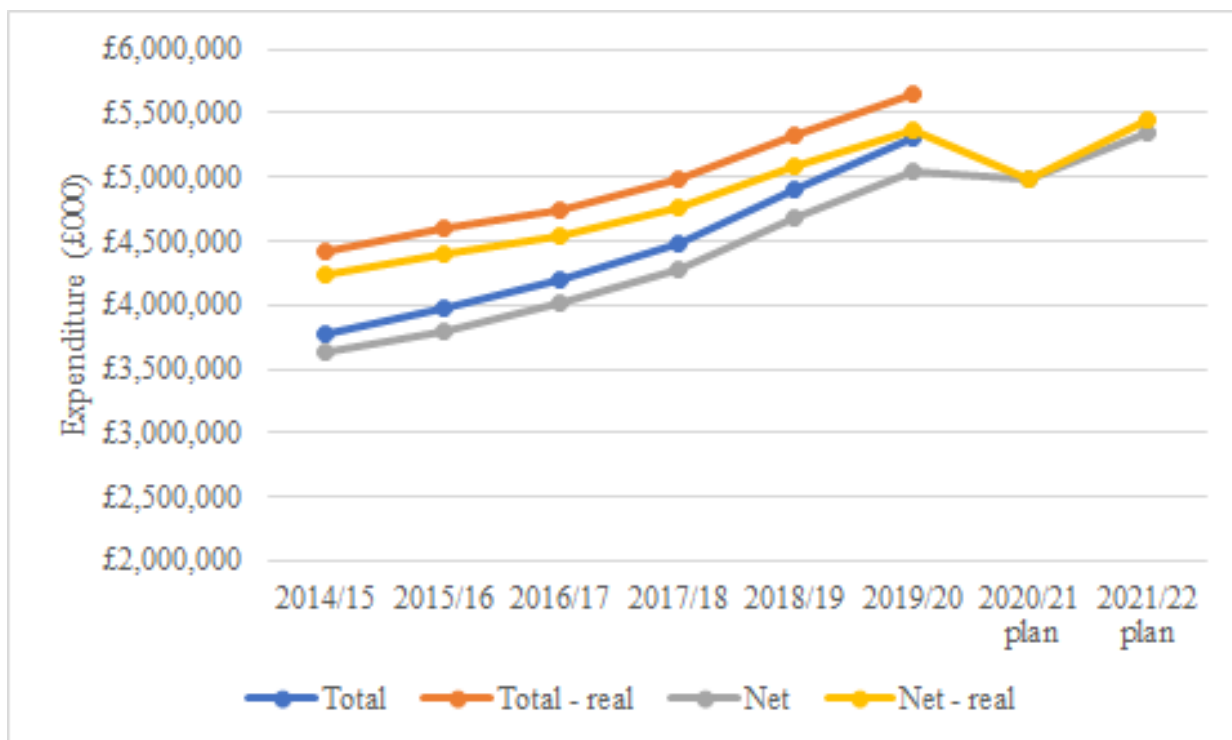
This means the share of children's social care expenditure devoted to these services has declined from 7.9% in 2014/15 to 3.7% in 2021/22 on the current planned net current expenditure. It would require spending to rise by around £440m in current prices to restore investment to that previous share.

**Chart 8. Social care spending by local authorities in England on Sure Start centres and early years, total and net current expenditure in cash and real terms (2020/21 prices), 2014/15 to 2021/22**



Spending data for looked after children shows that in terms of total expenditure, the amount has grown by 27.7% between 2014/15 (£4.421bn) and 2019/20 (£5.644bn) after adjusting for inflation, however spending growth appears to have slowed in recent years when looking at the planned level of net current expenditure, which has risen by 1.4% in 2021/22 (£5.442bn) compared to two years earlier (£5.368bn), having fallen in 2020/21 on the latest available data (£4.975bn).

**Chart 9. Social care spending by local authorities in England on looked after children, total and net current expenditure in cash and real terms (2020/21 prices), 2014/15 to 2021/22**



Together with Mental Health Policy Group, we are calling for early access hubs for children and young people to be made available in every local authority. Whilst these services would not be intended to replace existing statutory provision, they would reduce the significant pressures on services and work to reduce young people’s needs escalating to a point where they need more intensive and more expensive mental health support. As such, the roll out of open access hubs presents an early intervention solution to prevent unnecessary escalation in young people’s mental health problems, and higher overall costs to the NHS and society. This is particularly important to help abate the current rises in the prevalence of mental ill health amongst children and young people.

### *Social care – support for the first 1001 days*

The first 1001 days of life – from conception to age two, are critical for a child’s future cognitive and emotional development. Compelling evidence shows that what happens in this period therefore lays the foundations for children’s future health.<sup>155</sup>

That the pandemic has been difficult for many families has been well reported. Hidden harms for 0-2s including increased likelihood of exposure to traumatic experiences, restricted social interaction, less responsive parenting, and increased likelihood of hunger or material deprivation occurred at the same time that reductions in direct contact with most services removed key protections.<sup>156</sup>

Yet despite understandings of the pivotal importance of early childhood for later outcomes, and emergent evidence of harms to babies, no assessment has been made of the impact of the pandemic on the development of children aged 2 years and under.<sup>157</sup> Moreover, while over £3bn has been spent on mitigating the impact of the pandemic on older children, nothing has been spent on mitigating impacts on under 2s, despite the considerable potential for preventive interventions that dramatically improve outcomes and reduce pressure on health and social care services in the long term. Action is therefore needed to end the ‘baby blindspot’ in responses to the pandemic.

The Best Start for Life document sets out a compelling vision of how families will be better supported. It rightly recognises that greater spending on the first 1001 days is both important and needed, and that later interventions are more costly.

## Recommendations

1. At the 2021 CSR, the Government, the Department for Levelling Up, Housing and Communities and DHSC should commit to increase the social care budget for babies, 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 £440m in current prices.

2. The Start for Life Delivery Unit must be adequately resourced to meet the challenging vision outlined in the Best Start for life document. Investment will similarly be needed to ensure that every family has access to appropriate services in their area, including early support hubs and the Best Start for Life Offer.
3. DHSC/the Department for Levelling Up, Housing and Communities to invest £103m in each of the three years of the spending review, for the rollout of early support hubs to benefit an estimated 500,000 young people.

## Action 5: Invest in world-leading mental health research

Mental illness accounts for 23% of the global burden of disease in the UK<sup>158</sup>. Yet in 2018, just 6.1% of the UK's health research budget was spent on mental health<sup>159</sup> and this investment has remained flat for a decade.<sup>160</sup> This historic underinvestment in mental health research merits swift redress.

Spending on research on children and young people and intellectual disabilities is particularly constrained. Similarly, a lack of clinical drug testing involving older people results in excessive prescribing of off-licence medication.

High quality research evidence is also needed to better understand the impacts of COVID-19 on vulnerable groups.<sup>161</sup> Initial research has shown that the impact of the pandemic and lockdown on the mental health of children and young people to be substantial, particularly for those who are already disadvantaged or have specific needs. But there are multiple factors which may be affecting children and young people in different ways including lack of a school environment, family stress, domestic violence, reduced social and healthcare services, and a lack of social and leisure activities.<sup>162,163</sup>

The publication of the Mental Health Research Framework in December 2017, and the Roadmap for Mental Health Research in Europe (ROAMER) project, provides a helpful framework for increasing investment. Prevention across the lifespan is a priority research area in the ROAMER report.<sup>164</sup>

At the Spring Budget 2020, the Government announced £30 million of new funding for the National Institute for Health Research to undertake rapid research into COVID-19.<sup>165</sup> COVID-19 is driving an increase in mental ill-health and there is consequently a need for research into the direct and indirect psychiatric impact of COVID-19 from the short to longer term, and how problems should be treated, managed or mitigated.<sup>166</sup>

At the same time, the way in which certain types of research (e.g. on biological mechanisms and interventional trials) can be pursued has been challenged significantly by the pandemic and adjustments will

need to be sustained. Embedding research capacity within plans for infrastructural and service investment will be a productive strategy for best evidence-based practice.

A clinical research culture improves patient outcomes, workforce satisfaction and retention alongside a significant contribution to the UK economy. To ensure research influences policy and clinical practice at the earliest opportunity, researchers need easier access to existing datasets. 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, who typically work across both NHS clinical settings and universities medical schools or Higher Education Institutions (HEIs), are essential for leading research and development within clinical services. As leading educators, they are central to the development and delivery of education and clinical training of mental health workforce and inspiring the next generation of doctors specialising in psychiatry. However, academic departments are shrinking and there was a 21.7% decline in number of clinical academic psychiatrists between 2007-2016.<sup>167</sup> Trusts need to actively support academia with time in job plans and research and development infrastructure, otherwise clinical research will disappear and there will be no senior researchers to develop the next generation. There also needs to be greater diversity in academia as it is understood that approximately 80% of European graduates are female but only 20% are professors.

Without addressing this situation, improvements and innovations in NHS healthcare will stagnate and fall behind. Patients will not have access to the best care possible through a motivated and up-skilled workforce. The urgent need to correct disparity in mental health research investments need to be supported by proportionate investment into clinical academic careers and posts.

## Recommendations

1. DHSC to increase the funding for mental health research to 15% of the total UK research budget by 2030, drawing on the ROAMER priorities and research associated with COVID-19.
2. DHSC to allocate £120m 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>168</sup>

## OBJECTIVE 3: Investing in workforce

### *Workforce investment to date*

To date, there has been much needed investment in the mental health workforce, including the medical and non-medical workforce. Services are efficient, and lean, with managers and senior managers in mental health services down 23% in September 2020 (955) compared to September 2009 (1,243).<sup>169</sup> This means they represent just 0.8% of the mental health workforce in comparison to 2.5% across the NHS.<sup>170</sup> But an insufficient clinical workforce remains a significant limiting factor in delivering the Long Term Plan, reforming the Mental Health Act, and recovering from COVID-19.

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 £150m 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>171</sup> However, it is expected that this training budget will end by 2022/23.

In July 2020, HEE announced £10m to help support the growth of the clinical workforce and to expand the number of placements for people studying nursing, midwifery, and selected allied health professions. An additional investment of £28m was also announced on 21 September 2020 to support international nurses wanting to join the NHS front line.<sup>172</sup>

HEE received £60m as part of the People Plan funding for 2020/21. Just under half was allocated to mental health (£27.8m including Advanced Clinical Practitioners), showing the priority it was being afforded within the system. We were pleased to see HEE's continued investment in training the future mental health workforce, through expanding psychological therapies for children and young people and boosting the number of advanced clinical practitioners, psychiatrists and mental health nurses. There was 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. We are pleased that work is now underway on the NHS people and workforce strategy for 2022 and beyond.

Most recently, the March 2021 Covid-19 Mental Health and Wellbeing Recovery Action Plan detailed full allocation of the £500m for mental health and NHS workforce that had been announced at the 2020 Spending Review.<sup>173</sup> This included a £111m investment in the training and education of the NHS mental health workforce in 2021/22, to try and ensure we remain on track to deliver the NHS Long Term Plan and Mental Health Act reforms. In particular, this money was intended to:

- Increase the number of training places for psychology and psychiatry, with an additional 120 core psychiatry training programmes in key areas.
- Enable up to 950 recruit-to-train peer support workers to join the mental health workforce, and expand education and training posts for the future workforce.
- Develop advanced clinical practice programmes for mental health nursing and allied health professionals as well as deliver a range of programmes and upskilling initiatives.

### *Continuing workforce pressures*

Despite the investment in the mental health workforce to date, delivery of the Long Term Plan is still at jeopardy due in part to the impacts of the pandemic, but also to the slower than needed increases in particular parts of the psychiatric workforce, once headline growth figures amalgamating different staffing groups are broken down, as per original commitments.

Assuming current trends continue, just 150 consultant psychiatrists will have entered the workforce by March 2024 (based on NHS Digital workforce data from March 2017 - March 2021). This is against 830 needed deliver



the targets outlined in HEE's Stepping Forward and NHSEI's Mental Health Implementation Plan for the Long Term Plan. Similarly, consideration of the same trends for mental health nurses suggest we can expect around 2,000 more to be in post by March 2024, compared to the 9,250 required according to the two aforementioned strategies. So, we appear to be falling significantly behind targets, should urgent action not be taken.

HEE workforce modelling also shows the expected decline in psychiatry consultants in all of the main specialties, with the possible exception of general adult and forensic over the next 20 – 30 years. If services are to continue to be operational, additional posts will still be needed in CAMHS, Eating Disorders, Perinatal Psychiatry and Addiction Psychiatry - where we know there is an acute need to expand the workforce.

So, while we acknowledge there has been workforce growth overall to date, this has not been sufficient in the areas in which it is most needed.

Workforce requirements are expected to mount in line with the proposed Mental Health Act reforms. The reforms will lead to changes to the timescales for MHA tribunals, the responsibilities of psychiatrists during these tribunals, and the availability of second opinions, advocates and nominated persons. These in turn will alter the frequency of tribunals per detention, and the time required for each tribunal and detention. While the review aims to reduce the number of detentions overall, this very much remains to be seen, with some predicting a rise instead. Current workforce constraints indicate that extra work needed to implement these reforms cannot be absorbed by the existing workforce. HEE is commissioning independent research into the non-medical workforce needed to deliver the MHA reforms. Independent research commissioned by the Royal College of Psychiatrists<sup>174</sup> estimates the number of psychiatrists needed to deliver the reforms.

So, implementing the MHA reforms will require additional workforce over and above what is needed to achieve the Long Term Plan. As such, the success of the reforms will be dependent on investment to increase and train the additional workforce needed. We are therefore concerned that to-date this has not been factored into longer-term planning, either in terms of training or overall numbers.

Another area contributing to mounting workforce pressures is the cross-government all-age autism strategy for 2021-2026. This contains laudable objectives including improvements to the diagnostic pathway and reducing waiting times.<sup>175</sup> Successful delivery of the strategy will undoubtedly require investment into a substantial number of new posts, including consultant psychiatrists and associated spending on education and training, staff retention and development. We understand that a fully costed set of proposals has been submitted by NHS England and Improvement to that end and urge serious consideration of this bid to ensure the strategy can be placed on a strong footing.

This is also at a time when there are high levels of unmet need due to the pandemic. As outlined in previous sections above, official NHS statistics show significant increases in demand for mental health services. This means that responding to people who need care and support due to the pandemic is already a challenge, and one that will continue to exacerbate workforce pressures.

### *Growing the workforce*

In July 2021, it was announced that HEE had been commissioned by the Secretary of State for Health and Social Care to refresh its strategic framework for health and social care workforce planning. Understanding the factors that will have the greatest impact on future workforce demand and supply is critically important, especially in light of the impact of changing demographics and disease prevalence, patient and carer expectations, socioeconomic and environmental factors, staff and student expectations, technological and digital progress, and service models and pandemic recovery. This improved understanding will be highly useful as commitments and plans are formulated for the second half of the Long Term Plan, expected to commence in 2023/24, and beyond. As per the Health and Social Care Committee recommendation<sup>176</sup> and experts in the sector<sup>177</sup>, we urge that the forthcoming Health and Care Act includes a duty for the Secretary of State to report workforce numbers at the time of publication and projected supply for the following five,

ten and twenty years, and future workforce numbers based on the projected health and care needs of the population for the following five, ten and twenty years.

While this would provide much-needed clarity on whether the system is training and retaining sufficient people to deliver services both now and in the future, this alone isn't enough to solve the workforce crisis. However, it will provide the best foundations to take long-term decisions about workforce planning to keep up with population need. It should inform a long-term comprehensive NHS workforce strategy, building on the available resource to be set out in the 2021 CSR. Any workforce strategy should invest in workforce training and education to grow the mental health workforce, as well as in retention of the existing workforce.

As of September 2018, 46% of all NHS psychiatrists and 51% of consultant NHS psychiatrists in England had qualified abroad.<sup>178</sup> Recruiting from overseas is crucial for fulfilling workforce commitments required in the LTP. Indeed, 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, 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.

Since 2018 the government has funded an additional 1,500 medical training places per year. This was a welcome step to increase the number of home-grown doctors and increase supply over the long-term, however did not go far enough to put long-term workforce planning on a sustainable footing. COVID-19 has created an unforeseen growth in medical school places as a result of an unexpectedly high number of students qualifying for an offer to study medicine in 2021. In response, the government decided to provide extra funding to medical and dental schools across England and to increase the number of available places to 9,000 (of which 8,032 for medicine<sup>179</sup>). This is a positive development for the future psychiatric workforce. The uplift in medical school places should be retained for 2022/23 and expanded year on year, with 10,000 in 2023/24 and 11,000 in 2024/25, towards reaching 15,000 in 2028/29, as per the Royal College of Physicians recommendation.<sup>180</sup> This should be accompanied by assertive action over the longer term to ensure medical students become trainees in under resourced specialities, including psychiatry. This is necessary to deliver a sustainable supply of psychiatrists for the Long Term Plan period and beyond, and is all the more important in light of the extra psychiatrists that will be needed to deliver the MHA reforms, as detailed above.

The expansion in medical school places needs to be followed by a similar expansion in the number of training places at Core and Higher levels. A further expansion of Core posts is required to deliver the Long Term Plan and Mental Health Act reforms, as well as meet heightened demand due to COVID-19. Trainees are delivering services from day one, so an expansion of Core posts has a direct impact on service delivery. Additional Core trainee places, distributed strategically, could also help overcome geographical and specialty shortages if they are allocated in the right way.

Such an expansion needs to be coupled with a focus on retention of trainees. More core training places are also required to mitigate against the increasing diversity of training pathways. Research from UCL showed that psychiatry trainees overwhelmingly did not progress directly through training within six years, with only 14.7% completing training without delays, and 11 years being the average time taken to progress. It also found that trainees desired training arrangements to both support their progression and work-life balance, including allowing time out and Less Than Full Time (LTFT) hours.<sup>181</sup> Increased flexibility can increase the longevity of the workforce, but more psychiatry training places are required to support the gaps and reduce the burden on full time staff.

As well as improving recruitment and retention in mental health medical training, new roles, such as Physician Associates (PA) are an important part of meeting current and future workforce demands. We welcomed the commitment to expand PAs in training to over 1,000 per annum. In 2020, 2% of the PAs who responded to the Faculty of Physician Associates Census 2020 confirmed they were working in



psychiatry.<sup>182</sup> The introduction of additional PAs in the mental health system could further enable consultants, specialty doctors and trainees to work to the top of their skill set to improve productivity.

### *Workforce retention*

There are several factors that impact on retention of both trainees and older consultants that need to be addressed to ensure that new supply can have an impact. Data from 2019/20 showed 1,455 psychiatrists working in hospital and community health services left the NHS, in comparison to the 1,536 that joined the workforce over the same period.<sup>183</sup>

Work-related stress is caused by high demand and under-resourced services, including insufficient staffing levels and low recruitment. This leads to an increase in retirements amongst older consultants, as well as disincentivised trainees who desire greater flexibility throughout the training pathway, as a result.

Across the sector, there has been an increase in the number of doctors taking early retirement, with NHS figures showing that the numbers have tripled in the past decade. From 2007/08 to 2018/19, the number of GPs and hospital doctors in England and Wales taking voluntary early retirement or retiring because of ill health rose from 386 to 1186, and the average retirement age fell over this period, from 61 in 2007/08 to 59 in 2018/19.<sup>184</sup> Research also shows gender and specialty differences in retirement ages, and while there is a general societal expectation that people will retire at increasingly older ages, this is not reflected in the medical workforce. A 2018 study of retirement ages of senior UK doctors showed that psychiatrists and GPs retired at a slightly younger age than radiologists, surgeons, and hospital specialists.<sup>185</sup> It also showed that only 15.1% were working full-time in medicine, compared to pathology (17.7%), anaesthesia (19.2%), radiology (25.7%), hospital medicine (28.7%), and surgery (33.3%). This figure was the second lowest after GP (10.1%).<sup>186</sup> A 2021 survey undertaken by the Royal College of Physicians showed that retirements are an important reason for worsening staff shortages, with 27% of consultants expecting to retire in the next three years, with 42% of this group expecting to retire within the next 18 months.<sup>187</sup>

Alongside the Mental Health Policy Group, we believe there needs to be significant investment in retention and in mental health support for health and care staff, particularly after the strain put on them during the pandemic. This is needed both as a duty of care towards staff, but also to mitigate the impacts of mental health related absence, which has consistently been the most reported reason for sickness absence, accounting for 28% of absences since March 2020.<sup>188</sup> The duration of mental health-related absences was, on average, more than treble that of Covid-related absences between 1st June 2020 and 1st June 2021. The accumulative figure puts lost days to mental health-related absences at 2.5 million working days, compared to 2.1 million working days for Covid-related absences. The loss in productivity over the last twelve months is estimated to have cost the NHS more than £371.2m.<sup>189</sup> The Centre for Mental Health calculated that preventing a 1% increase in the rate of FTE absence rate of NHS staff saves approximately £476,000,000 per annum, based on the £47.6bn staffing cost in 2016/17<sup>190</sup>. This is the equivalent of providing a quarter of a million staff with mental health treatment worth approximately £2,000 per person as a breakeven exercise to reduce staff absence.

The Covid-19 Mental Health and Wellbeing Recovery Action Plan committed to £30m of funding for mental health hubs, which is equivalent to approximately £30 per NHS staff member. NHS staff have accessed the health and wellbeing offer 750,000 times, which shows that there is demand for these services. A long-term commitment to funding these mental health hubs is required. Published data on outcomes, number of contacts and the breakdown of protected characteristics of the staff accessing the hubs would enable evaluation of the effectiveness of the hubs, build on success and address gaps or concerns.

Another important factor in workforce wellbeing and retention relates to diversity. Data from the NHS Staff Survey Workforce Race Quality Standard condensed on the RCPsych Mental Health Watch data tool shows that many Black, Asian and Minority Ethnic staff are experiencing workplace based racism and

discrimination. In 2020, of the over 16,000 respondents of Black, Asian and Minority Ethnic background in mental health trusts, 86% had experienced discrimination on the basis of their ethnic background.

Against this context, we note the important and ongoing work of the Advancing Mental Health Equality Strategy Workforce workstream. No mental health trust staff should experience any discrimination on the basis of their ethnic background, or any other protected characteristics.

Finally, 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. This is particularly important in regions which struggle to recruit and carry long term vacancies, including the Midlands, South East, East of England, North East and Yorkshire and South West.

## Recommendations

At the 2021 CSR, the Government to commit to:

1. Increase the number of medical school places in England to 15,000 by 2028/29 at an estimated cumulative cost of £802m by 2024/25 (on the basis of places reaching 11,000 per annum by then) or around £1.73bn per annum when fully implemented in current prices when including the costs of the foundation programme or £936m per annum in current prices for medical school costs alone.<sup>191</sup>
2. 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 £64m of those cumulative costs to 2024/25 or costs of £138m per annum when fully implemented in current prices if 8% of the total new places are taken by doctors choosing psychiatry.
3. Continue the expansion of core psychiatry posts by making a further 120 additional posts available in 2022 and ensure provision for further expansion in the remaining years of the SR to facilitate long-term sustainability and growth in consultant psychiatrist posts. The additional core training posts made available from August 2021 onwards must be fully funded through the core training pathway, with sufficient provision also made for an expansion in higher training capacity.
4. Lay out plans to publish a comprehensive NHS workforce strategy following publication of HEE's strategic framework. This should be accompanied by 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 Long Term Plan, proposed standards from the Clinically-led Review of NHS Standards, and the proposed Mental Health Act reforms. The settlement must take into account that funding for postgraduate medical education and training has been essentially flat in real terms between 2013/14 (£2.111bn) and 2020/21 (£2.080bn).<sup>192</sup>
5. Ensure funding is allocated to deliver the requisite workforce for the Mental Health Act reforms. This includes the additional 332 FTE psychiatrists (including 255 consultants) needed by 2023/24, as identified in the independent research commissioned by the College, as well as the non-medical workforce to be subsequently identified by HEE-commissioned research.
6. Provide the necessary investment in workforce to deliver the autism diagnostic pathway and reduce waiting times. Funding is required for both new posts and education and training, while also supporting retention and development among existing staff in these services.
7. Maintain the NHS Staff Support Offer, with £50m funding each year over the three years.

8. Ensure that, from 2022/23 onwards, at least 10% of the 1,000 PAs being trained each year work in mental health (including liaison services and GP practices).

## Appendix 1: Case studies – Infrastructure

### Temporary modular facilities to increase real estate capacity in response to COVID-19



Portakabin offer three standardised ward solutions, which can be delivered in 6-12 weeks from design freeze.<sup>193</sup> These units include a temporary single storey standard ward unit:

- 8 bed ward – 6-week timeframe from design freeze.  
Internal layout = 187m<sup>2</sup>
- 20 bed ward – 8-week timeframe from design freeze.  
Internal layout = 500m<sup>2</sup>
- 37 bed ward – 12-week timeframe from design freeze.  
Internal layout = 949m<sup>2</sup>

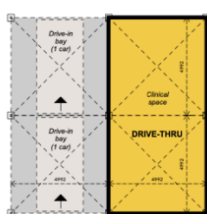
There are also:

- temporary shower blocks
- drive-thru testing
- decontamination zones
- quarantining areas, and
- hot hubs

### Standard modular layouts<sup>194</sup>



Drive-thru 3 x 1 tent layout  
Approx 15m x 5m



Drive-thru 2x2 tent layout  
Approx 10m x 10m

#### Module Layout - 'Drive Thru'

Based on dimensions by SHOWPLACE 5m modular tent (08.12.14)  
Received from NHS PS on 17.04.20

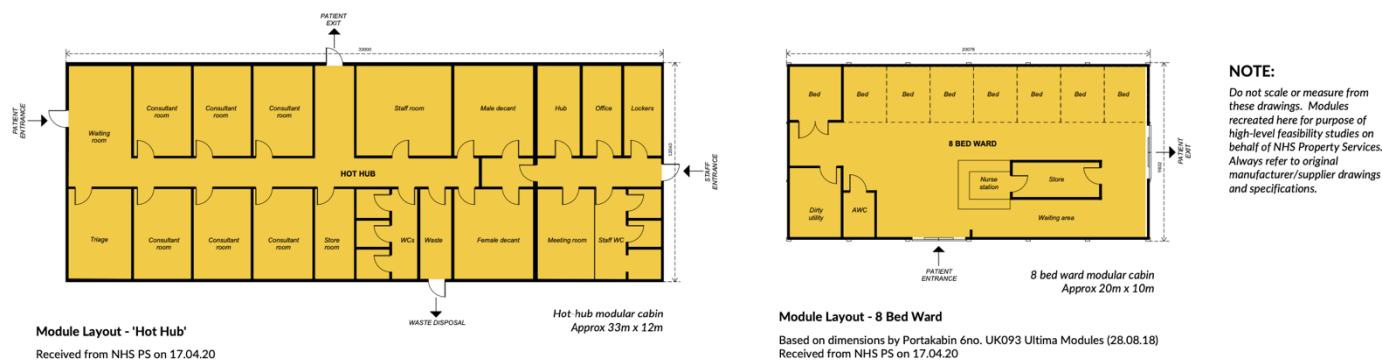
0 5 10 15 M



#### Module Layout - 20 Bed Ward

Based on dimensions by Portakabin 7no. UK123 double spanned to 7no. UK093 (12.12.19)  
Received from NHS PS on 17.04.20

8 bed ward modular cabin  
Approx 23m x 22m



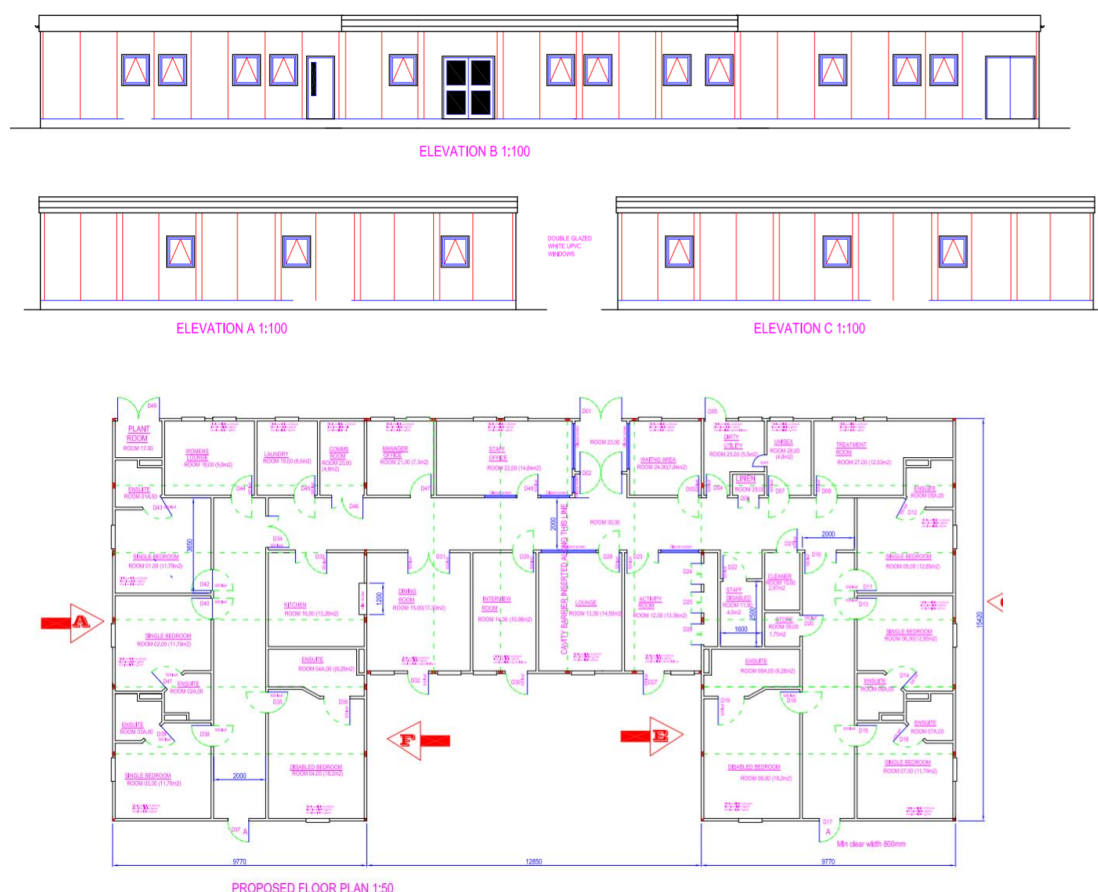
Most modular units come in multiples of 36m<sup>2</sup>, as that is the standard prefabricated module size, with some additional space needed for ramps to make them disability compliant (each modular section is equivalent to roughly 3 car parking spaces) and fire separation from other buildings. Prior to fitting modular units, there are a range of technical requirements that need to be considered.

Modular facilities are in the range of £1,525 - £1,800 per m<sup>2</sup> to purchase (excluding ground works and bespoke fit out). Rental costs range from £15 to £45 per m<sup>2</sup> per week, excluding ground works and bespoke fit out.

### *Blackberry Hill Hospital, Bristol – a modular mental health ward and ancillary accommodation*

Other options for modular buildings are given by Cotaplan who supply a variety of specially adapted modular buildings for various uses. Their NHS buildings can either be supplied as a shell or as a complete package including internal fit.<sup>195</sup>

Blackberry Hill Hospital, Bristol provides an example of where modular builds have been used for a mental health ward and ancillary accommodation.<sup>196</sup>



## Camden and Islington NHS Foundation Trust - reconfiguration of mental health inpatient beds<sup>197 198</sup>



The inpatient mental health services at the St Pancras Hospital site are provided in buildings that are not designed to meet modern health and safety standards, nor do they provide an ideal therapeutic environment. Some rooms are shared, access to outdoor space is limited, many rooms do not have en-suite facilities and the buildings pose potential safety risks which, although mitigated, require significant additional burdens on health care staff. The Trust spends significant sums of money maintaining the ageing buildings and ensuring they are safe – money that could be spent on staff time and clinical care.

Refurbishment of the existing accommodation to meet today's modern standards is not realistic. A significant level of investment would be needed to rebuild a hospital on the St Pancras site, including £55m for a decant facility and £61m for the actual rebuild.

There are a number of significant issues with the site at St Pancras Hospital, which refurbishment and renovation of the existing buildings would not resolve. These include the privacy and dignity of inpatient service users being compromised as there are approved developments plans around St Pancras for tall residential blocks (all to 12 storeys) with balconies overlooking the site. Due to the age and design of the estate, there are also access issues and considerable challenge in meeting disability access requirements, as outlined in the Equality Act 2010.

The proposal is to relocate the inpatient beds to a purpose-built mental health facility by the Whittington Hospital, opposite the Trust's Highgate Mental Health Centre. The new facility will retain the same number of beds as St Pancras Hospital but will mean the Trust can offer accommodation, which is welcoming, pleasant and safe for patients. All rooms would have en-suite bathrooms and there would be access to outside space from each ward. Facilities, such as a gym, to support recovery and wellbeing would also be provided.

Contract value: £59m for inpatient facility + £14.5m for land.



## Foss Park, Tees Esk and Wear Valleys NHS Foundation Trust – new build<sup>199</sup>



Foss Park is a new purpose-built, 72-bed mental health hospital which provides two adult, single-sex wards and two older people's wards (dementia and mental health conditions such as psychosis, severe depression or anxiety). All wards provide ground floor, single bedrooms with en-suite bathrooms. Each ward has access to outdoor garden areas and multiple therapy spaces, including the use of internal planted courtyards. It also has a Section 136 assessment suite – a place of safety for those who have been detained under Section 136 of the Mental Health Act - an electroconvulsive therapy (ECT) suite and dedicated space for research and development. York's adult and older people's crisis teams and the care home and dementia team will also relocate to Foss Park.

Contract value: £40.6m in Foss Park, which includes VAT, fees and the land purchase.

## Greater Manchester Mental Health NHS Foundation Trust – replacing dormitory accommodation through a redevelopment<sup>200</sup>



Greater Manchester Mental Health NHS Foundation Trust (GMMH) received £72.3m capital funding to replace Manchester's current mental health inpatient unit – Park House, based in Crumpsall on the North Manchester General Hospital site.

The unit, which currently has nine wards and 166 beds, will be completely rebuilt on the hospital site to provide an outstanding environment for high quality mental

health care in the city of Manchester.

GMMH became responsible for the delivery of services at Park House in 2017 and immediately recognised that the unit was a priority for improvement due to its traditional dormitory-style hospital accommodation and set about developing a business case to redevelop the facility. This multi-million-pound investment will greatly improve the quality of care for patients, supporting staff to care for patients in the best therapeutic environment possible.

Contract value: £72.3m

## Greater Manchester Mental Health NHS Foundation Trust – new build<sup>201</sup>



Atherleigh Park represented a major transformation in the care pathway and overall estate rationalisation for North West Boroughs Healthcare NHS Foundation Trust located in the heart of the Leigh community. The facility is now owned by Greater Manchester Mental Health NHS Foundation Trust as part of the transfer of North West Boroughs services across two trusts as of 1 June 2021.

The local community, service users, carers and front-line staff were fully integrated in the site selection process, this collaboration continued through the design and business case stages to the detailed decisions around interior design and art.

The completed facility provides high quality inpatient services for adults suffering from mental illness as well as patients with dementia and memory conditions. The facility comprises of 8-bed psychiatric intensive care unit (PICU), 40-bed working age adult and 38-bed later life memory service together with a central coffee shop, nature and trim trails, a dedicated sports hall and gym together with relaxation rooms, therapy rooms and activity gardens for each and every ward.

Whilst applying evidence based guidance, several innovative collaborative stakeholder events were undertaken. This included the design and construction team working closely with clinical staff to test 'a day in the life of' activities within key rooms mocked up on site to fully optimise layouts and details. All



departments were designed to maximise the use of both internal courtyard gardens (of which there are eight in total, two for each ward), and the external public realm. Within the public realm and shared spaces, service users, staff and visitors can safely interact in a place where the provision of care and support is balanced with an ability to integrate and blend with the everyday life of the community, with an ambition to aid rehabilitation and recovery and continue to de-stigmatise mental health.

Contract value: £40m.

### **Pennine Care NHS Foundation Trust – Woodland Retreat, treehouse-style unit for young people**<sup>202, 203</sup>



The retreat is the UK's first treehouse-style unit for 13 to 18-year-olds complete with decked area, barbeque and allotment. The 40m<sup>2</sup> urban lodge, built using sustainable resources, was designed and built by Blue Forest.

The treehouse has been designed to provide young people with a safe and stimulating environment in which to play, relax and learn. As well as undergoing therapy, young people will be able to

complete schoolwork, watch films and participate in nature-based activities as part of the team's therapeutic approach.

The Woodland Retreat is set in the natural woodland next to the Trusts' Hope Unit (acute psychiatric inpatient service for young people and their Horizon Unit (10-bedded unit providing complex care to young people who have severe or enduring mental health difficulties, including those who require high dependency care)).

The lodge can be used as an extension of their on-site educational facilities. Here the young people can learn about the natural environment, take in some fresh air, and enjoy the tranquillity of this outside space. Providing a peaceful space away from the normal clinical setting aims to enhance the treatment and personal experience of the young people by helping to reduce stress and tension. Its natural oasis is a stark contrast to the institutional environment of the hospital buildings.

It was built on a piece of wooded wasteland which offered good views of the surrounding countryside but was on a steep slope and unused. It was transformed into a useful, therapeutic environment offering plenty of flexible space. The design had to be eco-friendly and be appropriate to the surrounding.

Construction costs: £178,000.<sup>204</sup>

## South West Yorkshire Partnership NHS Foundation Trust- phased redevelopment masterplan<sup>205</sup>



South West Yorkshire Partnership NHS Foundation Trust is a specialist NHS Trust that provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. They also provide some medium secure (forensic) services across Yorkshire and the Humber.

Working together with ProCure22 they have designed and delivered 18 major facilities across the Trust's estate.

As part of the new Newton Lodge development, Interserve and their supply chain worked collaboratively with the Trust to develop a new approach to the anti-climb roll roof barrier. Developed in conjunction with their specialist suppliers, a mock-up was produced and tested rigorously by the Trust's security team. The specification is now used on all new wings of the lodge. The savings and benefits include a cost effective, low maintenance, secure roof removing the institutional appearance of the building.

Interserve has successfully delivered a programme of mental health and community services provision improvements throughout the Trust's estate, making it easier for service users to access high quality services in local, accessible hub buildings.

Each of the hubs houses a mix of outpatient services and staff accommodation, including adults of working age community mental health teams, CAMHS outpatient services and older people's services.

As part of an exploratory discussion around non-secure acute inpatients decant facilities, the team looked at the whole master planning of the Fieldhead site. The outcome was a phased solution that improved accessibility, quality of service provision. The £16m multi phased redevelopment masterplan, now well underway, is completely transforming the site and current facilities. Service users will benefit from state-of-the-art therapeutic areas, en-suite facilities with modernised visitor areas.

Contract value:£60m over 10 years.

## West Yorkshire and Harrogate Partnership – new child and adolescent mental health unit<sup>206</sup>



Planning approval has now been granted for a new £20m child and adolescent mental health unit for West Yorkshire is planned for St Mary's Hospital in Armley, Leeds. The bid, led by Leeds Community Healthcare NHS Trust on behalf of the West Yorkshire and Harrogate Partnership, will see a purpose-built specialist CAMHS unit support young people suffering complex mental illness from December 2021.

There are currently eight general adolescent beds provided by Leeds Community Healthcare in Leeds. The new unit, to the west of the city, will bring a significant increase - providing 18 specialist places and four PICU beds. This will see more young people being able to access specialist care closer to home, reducing the need for out of area placements.

Contract value: £20m



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- <sup>3</sup> High level estimate based on indicative information from the Psychiatric Liaison Accreditation Network (PLAN) at the RCPsych. However, Mental Health A&Es were established across the country during the pandemic and many have been created with limited planning and resources and are in facilities that are not fit for purpose in the long run. If this is to be desired model in some parts of the country, longer term establishment of such units will require capital and revenue funding.
- <sup>4</sup> Indicative modelling based on the costs of the South West Ambulance model and scaled up for national coverage.
- <sup>5</sup> This funding is on top of a subsequent recommendation for the recommendations of the Dame Carol Black review into drug treatment and recovery on revenue investment to be delivered in full.
- <sup>6</sup> This recommendation covers only the NIHR Biomedical Research programme, currently funded up to 2022. Additional funding streams would also be required to support delivery of the objective to double the proportion of research funding devoted to mental health and dementia by 2030.
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- (i) Mental Health (including Specialist Services) - sites exclusively providing mental health services including specialist mental health services e.g. secure units.
  - (ii) Learning Disabilities - sites exclusively providing learning disabilities services
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- Inadequate for Safety (acute wards: working age adults and psychiatric intensive care)
1. Leicestershire Partnership NHS Trust
  2. Nottinghamshire Healthcare NHS Foundation Trust
  3. Sheffield Health and Social Care NHS Foundation Trust

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Ageing estate (NB - As of most recent data in 2019/20, in order of highest proportion of estate built before 1948)

4. Tavistock and Portman NHS Foundation Trust
5. South London and Maudsley NHS Foundation Trust
6. Berkshire Healthcare NHS Foundation Trust
7. Surrey and Borders Partnership NHS Foundation Trust
8. Mersey Care NHS Foundation Trust

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