Mental health services in England: workforce, policy and practice issues

A report from Centre for Mental Health to the Tavistock and Portman NHS Foundation Trust, May 2017

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This report was commissioned by the Tavistock and Portman NHS Foundation Trust from Centre for Mental Health in February 2017. It provides a summary, at the time of writing, of the current policy landscape for mental health services in England and its implications for the workforce. It examines the current state of mental health services and their workforce. It reviews current mental health policy and the progress being made in its implementation. It explores the perspectives and positions of major national creators and influencers of mental health policy in England. And it reviews the emergence of STPs and other regional influences on delivery.
1. Mental health services in England

The NHS in England funds a broad range of mental health services including:

- Primary care: predominantly GP consultations and prescriptions
- IAPT: psychological therapy services, predominantly for adults with common mental health problems
- Secondary care: community, acute, crisis and rehabilitation services for working age and older adults
- Child and adolescent mental health services: community-based services for children and young people (including CYP-IAPT provision)
- Specialised (tertiary) services: including secure/forensic services, prison health care, inpatient CAMHS

The majority of secondary mental health care (especially community services) and CAMHS is provided by NHS trusts and foundation trusts. They also provide some IAPT services and approximately half of specialised services, most of which are commissioned by NHS England rather than CCGs. The NHS Confederation (2016) reported that there were 55 mental health trusts (including 43 foundation trusts) at the end of 2016. A significant number of these trusts also provide other health services, for example those commissioned to deliver community health care, learning disability or addiction services.

Voluntary sector organisations provide a wide range of services at all levels and for all age groups. Many are commissioned by NHS providers to work alongside them (e.g. in offering employment or supported housing services). Others are commissioned directly by CCGs or by local authorities, schools and colleges. In a growing number of areas, ‘prime provider’ or ‘alliance commissioning’ arrangements are emerging in which one local voluntary sector organisation holds the contract with the CCG and sub-contracts specific functions to other agencies.

Private, for-profit, provision accounts for almost half of NHS-funded specialised mental health services and is particularly well established in medium and low secure as well as locally (CCG) commissioned rehabilitation services.

Local authorities also commission a range of mental health services alongside CCGs and NHS England. These include adult social care (whose responsibilities include statutory roles in relation to the Mental Health Act), supported housing, public health, suicide prevention and counselling services for children and young people.

Who uses mental health services?

At the end of October 2016, there were 1,217,879 people of working age in contact with mental health services in England. This comprised 1,033,459 adults in contact with mental health services, 135,239 children and young people, and 71,684 people in contact with learning disability and autism services (NHS Digital, 2017). Data from NHS Digital’s monthly statistics shows that at the same time in 2015 there were 252,987 fewer people in contact with mental health services. Figure 1 shows an increase in the number of people in contact with mental health services between 2013 and 2016. It is unclear why the number rose so steeply in 2016 and whether or not this reflects a genuine rise in demand/provision.

At the end of September 2016, 1,825,905 people were in contact with secondary mental health care (including those in later life with dementia) and 5.6% of those were admitted to
hospital. In 2015/16 the total number of bed days was 7,699,525. By the end of September 2016, 18,734 people had been subject to the Mental Health Act of whom 13,475 were detained in hospital. The majority of people (95.4%) were supported in the community (NHS Digital, 2016).

*Figure 1: Number of people in contact with mental health services / learning disability services at the end of October/November 2013-2016.*

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1,000,000</td>
</tr>
<tr>
<td>2014</td>
<td>1,000,000</td>
</tr>
<tr>
<td>2015</td>
<td>1,000,000</td>
</tr>
<tr>
<td>2016</td>
<td>1,400,000</td>
</tr>
</tbody>
</table>

*Age*

Data for the year 2015-2016 shows that there was a total of 1,825,905 individuals of all ages in secondary care mental health services (NHS Digital, 2016). Table 1 outlines the number of people of each age group in the general population, in contact with secondary services, and the proportion of the population in contact with services. It is clear from Figure 2 that the 20-29 year olds had the most contact with secondary services (283,524), accounting for 15.5% of those in contact with secondary services. This is followed by 40-49 year olds, where 264,411 were in contact with secondary services. When comparing with the general population, 3.8% of 20-29 year olds are in contact with mental health services, whereas 20% of individuals aged 90 and above are in contact with secondary mental health services.

*Table 1: People in contact with secondary services broken down by age in 2015/16.*

<table>
<thead>
<tr>
<th>Age</th>
<th>People in contact with services</th>
<th>Percent of population in contact with services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,825,905</td>
<td>3.4%</td>
</tr>
<tr>
<td>15 or under</td>
<td>13,631</td>
<td>0.2%</td>
</tr>
<tr>
<td>16-17</td>
<td>22,042</td>
<td>1.7%</td>
</tr>
<tr>
<td>18-19</td>
<td>54,564</td>
<td>4.0%</td>
</tr>
<tr>
<td>20-29</td>
<td>283,524</td>
<td>3.8%</td>
</tr>
<tr>
<td>30-39</td>
<td>253,607</td>
<td>3.6%</td>
</tr>
<tr>
<td>40-49</td>
<td>264,411</td>
<td>3.5%</td>
</tr>
<tr>
<td>Age Group</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>50-59</td>
<td>223,015</td>
<td>3.2%</td>
</tr>
<tr>
<td>60-69</td>
<td>153,259</td>
<td>2.5%</td>
</tr>
<tr>
<td>70-79</td>
<td>200,893</td>
<td>5.0%</td>
</tr>
<tr>
<td>80-89</td>
<td>271,786</td>
<td>13.2%</td>
</tr>
<tr>
<td>90 or over</td>
<td>85,172</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

**Figure 2: Age breakdown of people in contact with secondary services in 2015/16.**

**Ethnicity**

In 2015/16 Black and Black British people made up 53,332 of the people in contact with secondary services, 2.9% (1,825,905). More Black or Black British people were admitted to hospital during this year than white people (15.3%:5.8%). This rose to 18.1% to people identified as Black African. Black, Black British and Mixed African and White and Mixed Caribbean and White people made up 9% of all admissions even though they only represent 3% of all individuals in contact with services. White people made up the majority of those in contact with services, 1,354,645 (74%) and 94.2% of those were seen within community teams (NHS Digital, 2016).
2. The mental health workforce

Psychiatry

Data provided by NHS Digital demonstrates that in September 2016 there were 8,819 psychiatrists (total number across all grades). This is 6.3% more psychiatrists than in 2009. It indicates that there is one psychiatrist to 6,157 people in the general population and one psychiatrist per 138 people in contact with mental health services.

Table 2: Number of psychiatrists in England NHS Trusts by specialism in 2016

<table>
<thead>
<tr>
<th>Psychiatrists</th>
<th>09/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Psychiatrists</td>
<td>967</td>
</tr>
<tr>
<td>Forensic Psychiatrists</td>
<td>549</td>
</tr>
<tr>
<td>General Psychiatrists</td>
<td>5709</td>
</tr>
<tr>
<td>Old age Psychiatrists</td>
<td>1090</td>
</tr>
<tr>
<td>Learning Disability Psychiatrists</td>
<td>421</td>
</tr>
<tr>
<td>Psychotherapy Psychiatrists</td>
<td>83</td>
</tr>
<tr>
<td><strong>Total Psychiatrists</strong></td>
<td><strong>8819</strong></td>
</tr>
</tbody>
</table>

Although before 2016 there were increases in the number of psychiatrists in England, there are challenges facing the profession, which are resulting in a shrinking workforce. First, attrition rates among consultant psychiatrists aged 53 or below have been substantially higher than average (CfWI, 2014). Second, almost one in five doctors in training failed to progress from core psychiatry training into higher speciality training (CfWI, 2014). Although there had been an increase in recruitment of first year core training, the average accepted offer of higher speciality training was 18% less. This problem was particularly observed in old age and child and adolescent psychiatry.

Mental health nurses and healthcare assistants

Data from NHS Digital demonstrates that in July 2016 there were 38,774 mental health nurses (2017d). The number of nurses has decreased by 16% since 2009, when there were 46,155. This loss can be mostly explained through reduced numbers of “other” psychiatry nurses, which accounts for 84% of the total reduction. Table 3 shows the number of mental health nurses broken down by community and “other” between 2009 and 2016.

In addition to these downward trends, the Royal College of Nursing (2014) discussed the problem of “downbanding” in the mental health nurse workforce, where there has been a fall in the highest bands of nurses. It noted:

"The information we have obtained shows that from April 2010 to April 2014 the NHS in England lost 612 band 6 nurses, 838 band 7 nurses and 488 band 8 nurses. This would indicate that senior nurses are being downbanded or losing their jobs, and being replaced with nurses on lower bands or health care assistants who cannot offer the same skills as those on higher bands. The RCN believes that in many circumstances, this downbanding is due to the need to reduce the overall pay costs rather than for clinical reasons.” (RCN, 2014)

Additionally, RCN research reported in The Guardian (2016) has highlighted the high numbers of vacancies among mental health nurses. Their research found that London
hospitals had 10,000 nursing vacancies and NHS mental health trusts were among the worst affected by shortages of nurses.

In response to the decrease in the number of mental health nurses, there has been more reliance on temporary and agency staff. By 2014, requests for temporary nursing in mental health services had increased by two-thirds (The King’s Fund, 2015).

Table 3. The number of community and “other” mental health nurses between 2009 and 2016. Source: NHS Confederation (2017)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Community Psychiatry</th>
<th>Other Psychiatry</th>
<th>Community Learning Disabilities</th>
<th>Other Learning Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>46,155</td>
<td>15,261</td>
<td>25,341</td>
<td>2,604</td>
<td>2,948</td>
</tr>
<tr>
<td>2010</td>
<td>45,384</td>
<td>15,666</td>
<td>24,581</td>
<td>2,508</td>
<td>2,628</td>
</tr>
<tr>
<td>2011</td>
<td>43,691</td>
<td>15,266</td>
<td>23,758</td>
<td>2,305</td>
<td>2,362</td>
</tr>
<tr>
<td>2012</td>
<td>42,446</td>
<td>15,386</td>
<td>22,749</td>
<td>2,176</td>
<td>2,136</td>
</tr>
<tr>
<td>2013</td>
<td>41,432</td>
<td>15,292</td>
<td>22,105</td>
<td>1,992</td>
<td>2,043</td>
</tr>
<tr>
<td>2014</td>
<td>40,357</td>
<td>14,966</td>
<td>21,615</td>
<td>1,907</td>
<td>1,870</td>
</tr>
<tr>
<td>2015</td>
<td>39,247</td>
<td>15,338</td>
<td>20,333</td>
<td>1,907</td>
<td>1,670</td>
</tr>
<tr>
<td>Jul-16</td>
<td>38,774</td>
<td>16,152</td>
<td>19,170</td>
<td>1,970</td>
<td>1,483</td>
</tr>
</tbody>
</table>

NHS Digital (2017d) has also released figures on the number of healthcare assistants in the workforce. As Table 4 shows, the vast majority of healthcare assistants work in inpatient settings, where the number has remained constant since 2009, and there has been a significant decrease in the number of community based healthcare assistants. This suggests that reductions in the nursing workforce have mainly taken place in inpatient services while healthcare assistant numbers have fallen in the community but not in hospitals.

Table 4: The number of mental health care assistants in 2009 and 2016. Source: NHS Digital (2016)

<table>
<thead>
<tr>
<th>Mental healthcare assistants</th>
<th>2009</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community nursing support staff</td>
<td>2,003</td>
<td>1,617</td>
</tr>
<tr>
<td>“Other” nursing support staff</td>
<td>19,340</td>
<td>19,341</td>
</tr>
</tbody>
</table>

Scientific, therapeutic and technical staff

The scientific, therapeutic and technical staff category includes allied health professionals such as occupational therapists and speech & language therapists, health scientists across a wide range of disciplines, clinical psychologists, and psychotherapists.

Data provided by NHS Confederation showed that there was an increase of over 7,000 scientific, therapeutic and technical staff from 19,064 in 2011 to 25,382 in 2014 (see Table 5), but in 2015 the number fell by 800.
Table 5: Number of FTE Scientific, therapeutic and technical staff in England, 2011-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Scientific, therapeutic and technical staff (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>19,064</td>
</tr>
<tr>
<td>2012</td>
<td>24,236</td>
</tr>
<tr>
<td>2013</td>
<td>25,434</td>
</tr>
<tr>
<td>2014</td>
<td>26,196</td>
</tr>
<tr>
<td>2015</td>
<td>25,382</td>
</tr>
</tbody>
</table>

NHS Digital (2017d) provides in-depth data, breaking down scientific, therapeutic and technical staff by profession. Table 6 shows the numbers of staff across professions relevant to mental health care. This table shows that decreases were only observed in music/art/drama therapy across this period. The biggest increases were in psychotherapy, which has increased by 3,088 professionals between 2009 and 2016. It appears to be the case that this is mainly people working in secondary care as IAPT is recorded separately.

Table 6: Number of therapeutic and social care staff by profession in 2009 and 2016.

<table>
<thead>
<tr>
<th>Professional</th>
<th>2009</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Music/Art/Drama therapy</td>
<td>462</td>
<td>351</td>
</tr>
<tr>
<td>Occupational therapy*</td>
<td>13,570</td>
<td>14,486</td>
</tr>
<tr>
<td>Clinical psychology</td>
<td>6,463</td>
<td>6,840</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>1,183</td>
<td>4,266</td>
</tr>
<tr>
<td>Social services</td>
<td>1,462</td>
<td>2,181</td>
</tr>
<tr>
<td>Music/Art/Drama therapy assistants and trainees</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Occupational Therapy assistants and trainees</td>
<td>2,447</td>
<td>2,871</td>
</tr>
<tr>
<td>Clinical psychology trainees and Assistant Psychologists</td>
<td>3,132</td>
<td>3,129</td>
</tr>
<tr>
<td>Psychotherapy assistants and trainees</td>
<td>299</td>
<td>1,025</td>
</tr>
<tr>
<td>Social service assistants and trainees</td>
<td>2,398</td>
<td>1,823</td>
</tr>
</tbody>
</table>

*It is unclear if the Occupational Therapy figures relate to both physical and mental health.

Psychological therapies

Data from the IAPT workforce census indicates that there were 6,980 FTE IAPT practitioners in 2015 (IAPT census 2015), 5,990 of whom were psychological wellbeing practitioners, counsellors and therapists. The IAPT census shows a 25% increase in the number of CBT therapists between 2012 and 2014, but a 22.5% reduction between 2014 and 2015.

Reduced numbers are observed amongst most HIT IAPT therapy specialisms between 2014 and 2015. There has also been a 24% decrease in the number of psychological wellbeing
practitioners between 2014 and 2015. Of important note is the increase in number of employment specialists employed in IAPT given the emphasis on multi-disciplinary teams. However, research indicates that the majority of people accessing talking therapies have not had access to the full range of recommended therapies (BPS 2014). A 2014 survey carried out by the We Need to Talk Coalition in England found that, out of 2,000 people who tried to access talking therapies, only 15% of them were offered the full range of recommended therapies by National Institute for Health and Care Excellence (NICE).

Social care

Data from the national minimum dataset for social care (2017) outlines the number of staff working in social care. The total number of staff in 2015/16 was 1,335,000, 84% of whom were British, 7% from the EU and 11% non-EU. A breakdown of this data reveals that there were 17,000 social workers, 800,000 support workers and 57,000 support and outreach staff in 2015/16. It is not clear from this data the proportion of time staff working in social care work within mental health.

Primary care

The total number of GPs increased between 2009 and 2014 (see figure three), but a reduction was observed between 2014 and 2015 by 3.2% (King’s Fund, 2015, NHS Digital, 2015). NHS Digital reported that in September 2015 there were 30,251 GPs (excluding registrars, locums and retainers). The King’s Fund (2015) presented the findings of modelling from NHS England and the Royal College of General Practitioners, which demonstrates that the rate of increase in GPs up to 2014 would not meet future demand. This finding was presented whilst the number of GPs was rising, which at the end of 2015 was no longer the case.

Unfilled GP posts has been an increasing concern and between 2010 and 2013 unfilled posts increased by 7.9% (Kaffash, 2013). There has been some improvement and Health Education England (2016) reported that in 2016 70% of trainee posts were filled. However, GP training was still the second worst filled specialism. The British Medical Association (2014) reported that GPs had the highest levels of stress and lowest morale across specialisms, making it a less attractive route.

Figure 3: The number of FTE GPs in England between 2009 and 2015.
There is no information available about the extent of the non-medical mental health workforce within primary care. However a number of practices and CCGs now provide mental health support within primary care, with roles such as ‘navigators’ to support people ‘stepped down’ from secondary care and those not accepted onto CMHT caseloads.

**Voluntary sector**

It is also important to consider the role of the third sector because it delivers a considerable amount of mental health care in England (King’s Fund, 2015). Lafond (2014) found that the voluntary sector accounts for approximately 20% of the mental health budget. However, data is not collected on this workforce and it is therefore difficult to assess their role in mental health provision. Anecdotally it is recognised that the voluntary sector (as well as other sectors such as education) and non-paid carers provide important mental health support whilst not being counted or formally recognised within the workforce.

**Private/ independent providers**

Independent healthcare provider numbers are captured within the overall figures presented. However, it is worth noting that independent healthcare providers are an increasingly significant part of the NHS provider landscape.

**Children and young people’s services**

Children and Adolescent Mental Health Services (CAMHS) deliver mental health support to children up to the age of 18. In 2015, there were 47 staff members in CAMHS to every 100,000 children aged 0-8 in contact with mental health services (NHS Benchmarking Network, 2013). The largest staff group working in CAMHS are mental health nurses. The Mental Health Network have also noted that community CAMHS have a very mixed, multi-disciplinary workforce, whereas inpatient care is almost entirely nursing.

**Gaps in the workforce**
NHS Benchmarking Network data for 2015/16 indicates a vacancy rate of 13% in adult acute mental health services in England and Wales. The staff sickness rate was 7% and turnover was at 12%. The same report found that bank and agency staffing accounted for almost 20% of these services’ staff costs, with bank staff at 12% and agency at 8%. There is evidence that attrition rates are particularly high for mental health nurses during their first two years following graduation.

There is also anecdotal evidence about significant variations between regions in the pressures facing the mental health workforce. Providers in London and the South East face very different issues to those in the North East and Cumbria, for example, relating to the local labour and housing markets.

**Nationality**

The NHS Confederation notes that there are approximately 144,000 EU nationals working in health and social care organisations across England: 80,000 in adult social care, 58,000 in the NHS, and 6,000 in independent health organisations. These are not disproportionately employed in mental health services, though there is also a substantial (not quantified) voluntary sector workforce from other EU countries. The impact of Brexit on these workers, and the organisations that employ them, is as yet unknown.
3. Mental health policy

The Mental Health Five Year Forward View

The Five Year Forward View for Mental Health (FYFV-MH) was produced on behalf of NHS England and the other ALBs by an independent Taskforce, chaired by Paul Farmer. It set out the priorities for NHS mental health care (and some wider recommendations for other government departments and agencies) in February 2016 (Mental Health Taskforce, 2016). The strategy’s major implications include:

- A call for all NHS staff to have greater knowledge and awareness about mental health
- The implementation of access and waiting time standards for adult Improving Access to Psychological Therapies services and for Early Intervention in Psychosis.
- Investment in new specialist perinatal mental health (community and inpatient) services
- Investment in ‘core-24’ liaison psychiatry services in general hospitals
- Expansion of the Improving Access to Psychological Therapies programme, with a particular focus on long-term physical conditions and medically unexplained symptoms
- Improvements to community mental health care, including crisis resolution and home treatment and Individual Placement and Support employment service.

The FYFV-MH was followed in July 2016 by an Implementation Plan which set out details of which of the report’s recommendations for the NHS would be delivered at what times up to 2021 (NHS England, 2016). The implications on the workforce are:

**Children and young people:** an extra 1,700 therapists and supervisors by 2020/21 and all services working within the CYP-IAPT programme.

**Perinatal mental health:** new multi-disciplinary teams providing evidence-based interventions and building relationships with other health services (e.g. maternity and health visiting).

**Common mental health problems:** 3,000 additional psychological therapists working in primary care and focusing on the needs of people with long-term conditions and medically unexplained symptoms, and of older people.

**Community, acute and crisis care:** developing a workforce to meet new standards for Early Intervention in Psychosis, to deliver Individual Placement and Support, to provide more physical health checks and psychological therapies to people with severe mental illnesses, and to extend access to liaison services in acute hospitals and to crisis resolution and home treatment services in the community.

**Secure care:** developing a workforce capable of supporting people in the community for people who do not (or no longer) need to be in secure mental health care.

**Health and justice:** expanding the liaison and diversion workforce, including a wide range of skills, backgrounds and competencies.

The implementation plan also notes the importance of supporting the mental health of the NHS workforce in order to improve quality and productivity, including through initiatives such as line manager training, providing rapid access to psychological therapies, mindfulness exercises and regular health checks.

The FYFV-MH notes that a mental health workforce strategy will be produced to support implementation of these pledges.
Future in Mind

Future in Mind (Department of Health, 2015) was the result of a Department of Health taskforce investigating how to improve child and adolescent mental health support. It set out a range of recommendations for improvement and required local areas to produce Transformation Plans in order to receive a share of the £1.25 billion investment over five years that was allocated to this process in the 2015 Budget.

Future in Mind states that:

"The national vision is for everyone who works with children, young people and their families to be:

- Ambitious for every child and young person to achieve goals that are measurable and achievable for them
- Excellent in their practice and able to deliver the best evidenced care
- Committed to partnership and integrated working with children, young people, families and their fellow professionals
- Respected and valued as professionals.” (p63)

Key features of Future in Mind with major workforce implications include:

- Creating ‘a [health, education and social care] workforce with the right mix of skills, competencies and experience’ that can ‘promote mental health’, ‘identify...problems early’, ‘offer appropriate support’, make referrals to targeted and specialist services and ‘work in a digital environment with young people who are using online channels to access help and support’ (2015:64)
- Multi-professional training for all paediatric staff in physical and mental health “and the development of service models (such as paediatric liaison) which recognise the interaction and overlap between physical and mental health” (2015:65)
- Staff in targeted and specialist services “need a wide range of skills brought together in the CYP IAPT core curriculum” (2015:65) (This programme currently covers 68% of the population and is a Mandate commitment to roll out further)
- A strategic approach to workforce planning: it proposes a ‘census and needs assessment’ of the workforce “as the first stage in determining a comprehensive cross-sector workforce and training strategy” (2015:67)
- Accredited training in children’s mental health “should be a requirement for all those working in commissioning of children and young people’s services” (2015:67)
4. Progress towards meeting policy ambitions

NHS England published a ‘one year on’ update on progress implementing the MH-FYFV in February 2017 (NHS England 2017a). It sets out what changes had taken place within the first year and how far the system was on track to meet its eventual goals. These include:

**Children and young people**

- An extra 21,000 children and young people receiving treatment (compared with 2014/15), with 150 new and 556 existing staff receiving training through the CYP-IAPT programme
- Plans are in place to spend the year’s allocation of £149m from Future in Mind, but “a small sub-set of CCGs have not planned to use this funding in full for this purpose”
- Extra inpatient beds for children and new waiting time standards for eating disorder services

**Perinatal mental health**

- New specialist services are being established in 20 areas covering 90 CCGs aiming to treat “at least 750 more women” this year
- A second wave of funding for other areas will be released next year
- Four new mother and baby units plus 8 extra beds in existing units
- Awareness training for non-specialist staff is being delivered to 3,000 staff this year
- A bursary scheme to fund training for extra perinatal psychiatrists

**Adult common mental health problems**

- An increase on last year of 72,500 people receiving IAPT services
- 22 new integrated services for people with long-term conditions seeing 6,000 people this year and aiming to see 30,000 in 2017/18
- 600 training places for new therapists
- Expanding the number of employment advisers within IAPT services

**Community, acute and crisis care**

- EIP services are already exceeding the target of treating 60% of people with first episode psychosis within 2 weeks: the number of referrals increased by 12% last year whilst staffing levels only rose by 9%
- NHS England has commissioned “a new three-year programme of work to deliver the first set of treatment pathways to define high-quality care for adults with more severe or complex needs in the community”
- Funding in the next two years to expand liaison psychiatry services “for adults and older adults”
- Published data on out of area placements to support “the ambition to eliminate inappropriate acute placements by 2020/21”

**Secure care**

A national audit of secure services has been complete and a model for community forensic services developed
Health and justice

Liaison and diversion services now cover 68% of the population and are “on track to meet the planned 100% coverage by 2019/20”

Suicide prevention

95% of local authorities now have a suicide prevention plan; “a quality assessment of local plans is to take place later this year”

Testing new approaches

- Six pilot sites for providers to take responsibility for commissioning (4 adult secure, 2 CAMHS inpatient) begin work in April 2017
- Nine pilot sites testing new models of CAMHS crisis care
- Digital approaches, including updating NHS 111 and improving self-referral to IAPT through NHS Choices

System changes

The revised CQUIN framework for 2017-19 includes:

- “more coherent pathways between children’s and adult settings”
- “to ensure people presenting at A&E with psychosocial needs have these needs met”
- Meeting physical health needs of people with a severe mental illness

Next Steps for the Five Year Forward View

NHS England’s recently published implementation plan for the Five Year Forward View (2017b) reinforces the importance of mental health, alongside cancer, primary care and A&E, as a key priority. It notes specifically:

- There will be “74 24-hour ‘core 24’ mental health teams, covering five times more A&Es by March 2019, than now. The service will be available in more than a quarter of acute hospitals by March 2018 and reach nearly half by March 2019, compared with under one-in-ten today.”
- “800 mental health therapists will be placed in primary care by March 2018 rising to over 1500 by March 2019. These therapists will lead the way in how we integrate physical and mental healthcare outside of hospital.”
- There will be “an extra 140,000 physical health checks for people with severe mental illness in 2017/18, rising to 280,000 health checks in 2018/19.”
- The establishment of a “single national programme management team led by a national mental health director and national clinical director, aligning the work of NHS England, NHS Improvement, Health Education England, Public Health England, and the other Arm’s Length Bodies.”

Transforming children’s mental health services

There has been little independent analysis as yet of progress in relation to the MH-FYFV. However, the Education Policy Institute has been investigating the implementation of Future in Mind. Its review (Frith 2017) identified wide variations in the quality and comprehensiveness of the 123 Local Transformation Plans that were developed in 2015 and
in the number of CCGs that were meeting NHS England’s performance measures for improving CAMHS in 2016. Specifically, it found:

- Less than a third of CCGs had a fully funded plan to improve children’s crisis care (and 10% had no plan at all)
- 90 young people were staying on adult acute inpatient wards (half of them in the North of England)
- Wide variations in per capita CCG spending on children’s mental health (from £23 in the bottom quartile to £52 in the top quartile)
5. Government and Arm’s Length Bodies

Department of Health

The DH is responsible for overall development and delivery of health policy. While most of the day to day management of the DH’s functions are devolved to its Arm’s Length Bodies, the Department retains some important roles including:

- Making and reviewing legislation: the Mental Health Act and Mental Capacity Act are particularly relevant to mental health services, but also the Care Act
- The NHS Mandate: the DH sets out its expectations of its ALBs in the form of a Mandate which is refreshed every 2-3 years, and more broadly in the NHS Constitution
- Performance monitoring: the DH has a ‘system steward’ role in holding the NHS to account for its performance against agreed targets
- Strategies: the DH is developing a 10-year mental health research strategy and a mental health data strategy as part of their role in implementing the Mental Health Five Year Forward View; both are yet to be published.

Arm’s Length Bodies (ALBs)

NHS England

NHSE is responsible for the commissioning functions of the NHS, both as a commissioner of specialised services (which account for about one-third of mental health care spending) and as a regulator and authorising body for CCGs.

NHSE commissioned the Mental Health Taskforce to produce the MH-FYFV and leads the NHS elements of the implementation programme. It is responsible for a number of work programmes to deliver the pledges in the strategy, including:

- IAPT (adult and CYP)
- Perinatal mental health
- New Models of Care
- Liaison Psychiatry

NHSE also recently announced the creation of a single team, led by its director of mental health Claire Murdoch, working across the Arm’s Length Bodies to oversee implementation of the MH-FYFV.

NHS Improvement

NHSI is the regulator of NHS providers. It describes itself on its web site in the following way:

"NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future."
NHSI’s role includes developing the emerging payment system for mental health services. It is also supporting Lord Carter’s review of ‘operational productivity and performance’ in mental health and community services which is due to report later in 2017. The review’s remit has been described as including “what good looks like; what approaches to improving productivity and efficiency are already in place and what opportunities there are to drive these further; and what metrics and indicators are required” (NHE, 2017)

Health Education England

HEE is responsible for NHS workforce planning, education and training in England. It is producing a workforce strategy for the MH-FYFV.

HEE also produced, with Skills for Health and Skills for Care, a Mental Health Core Skills Education and Training Framework (2016) which aims to “support the development and delivery of appropriate and consistent cross-sector education and training for those working with individuals with mental health problems...by setting out the core skills and knowledge that are transferable and applicable across all different types of service provision” (2016, p4). The framework identifies three ‘tiers’ of staff working in a range of public services, from those who require general mental health awareness, to those who have “some regular contact” with people with mental health problems, and those who support people with a mental health problem.

Care Quality Commission

The CQC is the quality regulator for health and social care providers. It inspects all health and care service providers as well as having a specific role in relation to the Mental Health Act in safeguarding the rights of people who have been detained. As well as carrying out inspections of NHS providers it runs regular surveys of people using community mental health services and produces reports on specific areas of concern. It can also carry out joint inspections and reports with other regulators, such as Ofsted (for children’s services), HMIP (for prison health services) and HMIC (for police custody healthcare).

NHS Digital

NHS Digital is the Arm’s Length Body whose role is described on its web site as “to improve health and social care in England by making better use of technology, data and information”. It publishes data (including the Mental Health Services Data Set), provides information systems to NHS organisations and sets standards for data collection and management.

National Institute for Health and Care Excellence

NICE is the standard-setting body for the NHS, public health and social care in England. It produces guidelines in each area to identify cost-effective interventions and set standards for local commissioners and providers. It produces a range of different outputs including:

Technology appraisals – predominantly for pharmaceuticals and surgical interventions, which are mandatory for NHS organisations to follow
Clinical guidelines – for specific medical conditions or types of care and support
Quality standards – building on guidelines, these “set out the priority areas for quality improvement in health and social care...where there is variation in care”
The majority of NICE activity in relation to mental health comes in the form of clinical guidelines, and while these are not mandatory under the NHS Constitution they set out a range of expectations for commissioners.

Public Health England

PHE is responsible for protecting the nation’s health. Its responsibilities include infection control, health promotion, knowledge and intelligence. Its health improvement directorate includes a dedicated mental health team which is responsible for suicide prevention (encouraging and supporting local strategies), developing the public mental health workforce and improving the physical health of people with mental health problems. PHE also hosts the Mental Health Intelligence Network, through which data is available to inform local needs assessments and strategies.

PHE’s main responsibility from the MH-FYFV is to develop a Prevention Concordat programme to support local authorities to take action to promote mental health and prevent mental illness in communities.

Regional and local bodies

PHE and NHSE both have regional structures with offices that carry out their statutory functions (eg PHE’s observatories and NHSE’s specialised commissioning) and support local bodies (LAs and CCGs respectively). The NHS also has a number of Clinical Networks at the regional level for mental health which provide additional support, advice and learning opportunities for CCGs. Clinical Networks have, for example, coordinated the development of Zero Suicide programmes in the South West and East of England, and supported the development of primary care mental health in London.

The NHS also has a network of Academic Health Science Networks (AHSNs) whose role is to translate clinical evidence into practice at the regional level. AHSNs vary in their level of engagement in mental health but some, including UCL Partners and King’s Health Partners, have significant programmes (e.g. KHP’s work to improve the physical health of people with severe mental illnesses).
6. National policy influencers and lobby groups

Centre for Mental Health (author of this paper)

The Centre uses research to ‘bring about better services and fairer policies’ in mental health. Its recent and current areas of focus include:

- Children and young people – with a particular focus on perinatal mental health, children with behavioural problems, marginalised young people and youth justice
- Criminal justice – including liaison and diversion, prison suicide prevention and support for people leaving prison
- Employment – expanding the availability of Individual Placement and Support across England and adapting IPS to other services (e.g. in primary care or for armed forces veterans)
- Integrated care – building stronger links between mental and physical health support, both in hospitals and in primary care
- Veterans – working with the Forces in Mind Trust to develop evidence about how to support mental health among people leaving the armed forces
- Workforce – developing a workforce for the future and supporting innovation in mental health services

The Health Foundation (THF)

The Health Foundation’s focus has traditionally been on supporting quality in health care through grantmaking and policy analysis, funding occasional projects in mental health services. It has an increasing focus, however, on ‘health creation’ and early intervention and it has published evidence reviews on Asset Based Community Development (Hopkins and Rippon 2015) and other promising approaches to prevention.

The Nuffield Trust

The Nuffield Trust’s QualityWatch programme (jointly run with THF) produces a suite of regular updates using nationally available data on mental health services. These include:

- Community mental health care reviews: exploring what proportion of people on CPA have an annual review meeting and how involved they feel in their care
- Follow-up care for adults with mental health problems: detailing whether people are contacted within seven days of hospital discharge
- Improving Access to Psychological Therapies: reviewing data on referrals, waiting times, needs and outcomes
- People’s feelings about their mental health care: reviewing CQC data about whether people using community mental health services felt listened to, treated with respect and given time to discuss their needs and treatment.

QualityWatch also publishes blogs on related topics, including the recent National Confidential Enquiry into Patient Outcome and Death report on the physical health care provided to people with long-term mental health conditions in general hospitals.

The Nuffield Trust also carries out research and analysis on the health and social care workforce. A major report (Imison et al 2016) explored ways in which the NHS can implement new models of care by reshaping its existing workforce, with a particular focus
on making better use of non-medical staff. Key observations from this report (which did not focus specifically on mental health care but are equally applicable) include:

- The NHS faces ‘growing and acute’ workforce pressures, with 50,000 vacant clinical posts (in 2014), an agency bill of £3.7bn (in 2015/16) and each year more nurses leaving the profession than joining it
- London faces particularly high vacancy rates, including 30% for nursing posts in one mental health trust
- Poor role design across health services, with three-quarters of both doctors and nurses ‘over-skilled’ for their roles while 20% of health care support workers were being asked to work beyond their competence
- Workforce planning in the NHS has placed ‘reliance on provider plans for its workforce planning assumptions’ which has limited their length of vision and their level of ambition (Imison et al 2016)

The report calls for ‘more flexible pathways within and between professional groups’ (for example by training support staff in taking on clinical roles) and for ‘pathways to help bridge the gap between different parts of medicine, particularly between primary and secondary care’ to fill gaps in general practice.

The King’s Fund

The King’s Fund has published some significant reports and commentaries on the development of mental health services and on the links between mental and physical health care. Its report *Bringing Together Physical and Mental Health* (Naylor et al 2016) set out a range of examples of local services that provide effective support across the traditional divide, including for people with long-term physical conditions and common mental health problems; for people with medically unexplained symptoms; and to support the physical health of people with a severe mental illness.

The Fund has been monitoring STPs and encouraging them to ensure that New Models of Care such as multispeciality community providers (MCPs) and primary and acute care systems (PACS) include mental health from the outset, with “access to appropriate mental health expertise” (Naylor 2016). And it is currently investigating the scope for improved mental health support in primary care with a conference on 7 June.

The Fund has also reported on spending pressures in mental health services (Gilburt, 2016) and noted in particular the tendency of mental health service providers to live within spending limits set by commissioners and thus to make cuts to services through ‘transformation programmes’ that, in its view, have reduced quality and safety. It points out that since 2009 there has been a “reconfiguration of the evidence-based services implemented under previous national programmes, notably the National Service Framework for Mental Health, in favour of care pathways and models of care in which the evidence base on what works is often limited. These initiatives represent a leap in the dark, with little formal evaluation to indicate impact on the quality of or access to care” (Gilburt, 2016).

Royal College of Psychiatrists

RCPsych is both a representative and regulatory body for psychiatry in England and Wales. It is comprised of a number of faculties representing different specialities within the profession.
As well as its statutory functions, RCPsych produces research, commissioning guides and public information. Its most significant recent report is the Independent Commission on Acute Inpatient Care (‘the Crisp Commission’) which set out an agenda for improving acute and crisis care, recommending major improvements to community services to prevent or manage crises. The Commission’s recommendations were supported by the MH-FYFV and have been incorporated into its implementation plan. They include:

- A waiting time standard of four hours for emergency mental health care (either admission to an acute psychiatric ward or acceptance for home treatment)
- Phasing out long-distance out-of-area placements for non-specialist treatment
- Better access to housing options as alternatives to admission or for step-down following discharge

**Royal College of GPs**

RCGP has two current mental health ’clinical champions’, Dr Liz England (for mental health) and Dr Judy Shakespeare (for perinatal mental health) who have led programmes of work within the College to improve GP awareness and knowledge. The perinatal clinical champion programme, for example, has produced an online learning resource and developed research projects to help GPs identify women with perinatal mental health difficulties.

**Mind**

Mind played a major part in developing the MH-FYFV and continues to play a big part in overseeing its implementation, while it also has active campaigns nationally in relation to mental health services, welfare rights and workplace mental health.

**Rethink Mental Illness**

Rethink is both a significant provider of a wide range of services and a national campaigning organisation on behalf of people with severe mental illness. Its campaigning priorities include mental health care funding and supported housing provision. In partnership with Mind, it jointly manages the high-profile national Time to Change anti-stigma and discrimination campaign.

**NHS Confederation**

The NHS Confederation’s Mental Health Network is a representative body for all providers of NHS mental health services, including trusts, foundation trusts, private and voluntary sector organisations and supported housing providers. As well as lobbying on behalf of its members, for example for fair funding for mental health care, it plays a significant role in seeking to improve wider policy and practice. Its current priorities include future workforce planning and improving access to digital mental health support.

The Confederation also hosts NHS Clinical Commissioners which includes a sub-group for mental health commissioning leads in CCGs.

**NHS Employers**

NHS Employers seeks to be “the voice of employers in the NHS...[and] to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.” It negotiates pay on behalf of employing organisations in the NHS as well as
advising and supporting them on workforce planning and providing updates on the implications of policy.

NHS Employers led a national campaign to support the mental health of staff working across the NHS and developed an emotional wellbeing toolkit for health service organisations¹.

**NHS Providers**

NHS Providers is the representative body of NHS trusts and foundation trusts. It is increasingly vocal in raising concerns about the funding of NHS provider services and about the lack of ‘parity’ for mental health services.

**Local Government Association**

The LGA is the representative body for all English local authorities. Its main areas of interest in mental health centre on councils’ key responsibilities in social care and public health. It currently has a major focus on the roles of local authorities in children’s mental health and in crisis care.

**Psychological therapy bodies**

A large number of representative and regulatory bodies exist for psychological therapists in England. The three major professional bodies for counsellors and psychotherapists (BACP, UKCP and BPC) work increasingly collaboratively on policy development and lobbying on behalf of their members. BACP in particular is also a commissioner of research in relation to counselling and psychotherapy.

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7. Innovations identified by key influencers

This section gives examples of local innovations and approaches that have been cited as good or promising practices by national policy influencers in recent years.

The King’s Fund report *Bringing together physical and mental health* (Naylor et al 2016) identified a number of local service innovations that it regards as exemplary of the need to integrate care. Several of these have been highlighted in other reports and service evaluations:

**Three Dimensions for Diabetes**: covering Lambeth and Southwark, this service offers psychological and social support for people with diabetes alongside their physical health care within an integrated team.

**Oldham persistent pain pathway**: providing holistic support for people with chronic pain in both primary and secondary care.

**City and Hackney Primary Care Psychotherapy Service**: also evaluated and highly commended by Centre for Mental Health for working within primary care to meet the needs of people who often fall between primary and secondary care and receive little effective help in most areas (Parsonage et al 2014).

**Oxford Psychological Medicine Service**: a liaison psychiatry service managed by the acute trust, noted to be highly integrated into the trust’s other services.

**Hull psychological medicine department**: a liaison psychiatry service noted for providing a range of interventions beyond assessment and identification (i.e. the ‘RAID’ model), currently seeking to reach out to primary care as well as working within the hospital (this was also noted as exemplary in Centre for Mental Health’s review of liaison psychiatry, Parsonage and Fossey 2012).

**LIFT Psychology, Swindon**: a tiered psychological therapies service providing a stepped care model for people with long term conditions and medically unexplained symptoms.

**Bradford physical health checks**: a widely recognised approach to proactively offering physical health checks to people with mental health conditions in both primary and secondary care; this service is also cited in Imison et al (2016) as an example of innovative workforce planning by employing four associate practitioners to carry out the health checks.

**West London secure services primary care**: a primary care practice working in two secure hospitals providing a comprehensive GP service.

**Physical health liaison in Highgate**: offering physical health support to people detained in a psychiatric unit.

**Devon and Torbay perinatal health team**: offering integrated care to women using maternity services. (Naylor et al 2016)

The Nuffield Trust’s *Reshaping the workforce* report (Imison et al 2016) also cites **Nottingham CityCare Partnership** as an example of good practice by creating a new ‘holistic worker’ role at the assistant practitioner level “to assess a patient’s complete needs”. And it cites **Birmingham and Solihull Mental Health NHS Foundation Trust** as (to its knowledge) the only mental health trust to employ physician associates “to perform mental and physical health assessments, take on some tasks previously performed by doctors and provide long-term continuity of care”.

The King’s Fund, meanwhile, has also supported through its leadership development team the **Forward Thinking Birmingham** service which delivers mental health services to children and young people up to age 25, one of a small number of services to work beyond age 18. It notes that this model requires a significant cultural shift for both child and adult mental health services and needs “a particular kind of leadership – leaders who can work..."
across organisational boundaries; who are willing to share power and resource in pursuit of a shared vision (Kaur 2017).

The Royal College of Psychiatrists’ report *Old Problems, New Solutions* (Crisp et al 2016) identifies a number of exemplars for improving acute mental health care, including:

**North East London** NHS Foundation Trust: redesigning its adult acute care services through a ‘single point of access/referral’ Access Assessment and Brief Intervention Teams and an emphasis on Home Treatment Teams as an alternative to admission

**Greater Manchester West** Mental Health NHS Foundation Trust: a redesigned care pathway with expanded crisis team provision, longer working hours for CMHTs, a seven-day helpline and reduced bed numbers

**Collaborative commissioning** in Essex: bringing together NHS and local authority commissioners to jointly commission “a single new county-wide provider for emotional wellbeing and mental health services for children and young people”

**Tile House**: a housing development for people with ‘high levels of risk and complex needs’ in North London which has been shown to prevent or shorten hospital admissions (widely cited in other documents as an exemplar for the crisis house model)

The **Purposeful Inpatient Admissions** model: an approach adopted by Tees, Esk & Wear Valleys NHS Foundation Trust to improve ways of working in inpatient services, resulting in reductions in bed occupancy, lengths of stay, violent incidents and staff sickness

The **Triangle of Care**: a way of working in partnership with carers and family members of people using mental health services, also commended in a recent Centre for Mental Health briefing paper (Matthews 2017) and widely regarded as best practice

**Drayton Park** women’s crisis house: the sole women-only residential crisis house in the UK.

In addition to examples cited above, Centre for Mental Health has also given as examples of good and effective practice in its recent work:

**Sheffield Mental Health Citizens Advice** service: demonstrating the value of high quality welfare advice to people using mental health services (Parsonage 2013)

**The INTEGRATE model**: identifying the benefits of working with marginalised young people in communities to provide mental health support (Durcan et al 2017)

**Individual Placement and Support**: the Centre has identified a number of local ‘Centres of Excellence’ that provide high-fidelity IPS to support people into employment

**Housing First**: an approach to supporting homeless people with complex needs with a growing international evidence base (Boardman 2016)

**Joint strategic needs assessments**: citing five examples of high-impact mental health JSNAs in local areas (Bell 2016)

*The vision for services*

The picture that emerges from the innovations and approaches featured in these reports is of services that:

- Provide support for mental and physical health and social/economic needs in an integrated fashion
- Link up primary and secondary care, for example providing expert advice to GPs and extending primary care mental health provision
- Make use of a wider workforce, including the new roles such as assistant practitioners and physician associates, to fill gaps in current provision
• Create more efficient pathways through services, particularly for people facing crises and requiring hospital admissions or alternatives (either through home treatment or crisis houses)
• Intervene earlier to prevent problems escalating into crisis
• Support recovery through connections with other services, including housing and financial advice

The vision for the workforce

The implications of this vision for the workforce are considerable. It is evident that all of the innovations cited require staff to work ‘flexibly’. In some cases, they require new roles to be created (eg assistant practitioners, ‘navigators’, ‘holistic workers’). In others, they require existing roles to work in new ways, eg secondary care staff reaching out to primary care, or expansions in roles that are associated with effective service models (eg IPS employment specialists).

There is also a clear message that both policy imperatives and new service models will bring about significant shifts in the ways services are provided and commissioned. New organisational models are emerging, for example GP federations, ‘care communities’ and ‘hubs’ that scale up primary care and create settings for mental and physical health care to be provided together. This will have an impact on staff, both by creating new opportunities to work differently and by bringing about greater uncertainty in an already uncertain time for health and care workers.
8. Sustainability and Transformation Plans

Sustainability and Transformation Plans were created early in 2016 as a result of NHS England Planning Guidance requiring providers and commissioners to work together to address the sustainability of their local health economies. These were all published by the end of October 2016.

STPs and mental health

Most STPs include at least some mention of improved mental health support. It is unclear as yet, however, how far STPs are going above and beyond plans already in place through the MH-FYFV. NHS England has said that it will scrutinise STPs for the quality of their mental health proposals but it is not known what 'good' or 'good enough' look like or what action will be taken where STPs fall below the expected standard.

The King’s Fund has reviewed all 44 STPs (Ham et al 2017) and identified the key themes contained within them. They include:

- Changing the roles of acute and community hospitals: reducing acute hospital capacity, reconfiguring services between hospitals and reviewing specialised services
- Redesigning primary care and community services: “delivering more services outside of hospitals and in people’s homes…invariably [they] describe commitments to break down barriers between services and to develop care that is more integrated”
- Strengthening prevention and early intervention: working outside the traditional scope of health services to focus on the determinants of health
- Improving mental health and other services: including maternity, learning disability and children’s services
- Improving productivity and tackling variations in care: implementing recommendations from Lord Carter’s review of hospital efficiency and reducing variations in activity and productivity
- Workforce: tackling “problems relating to staff recruitment and retention” including greater cooperation between organisations within STP areas, reducing staff sickness absence and supporting new roles

Plans noted by Ham et al (2017) with specific proposals relating to mental health services include:

**London**: five STPs all involved in a review of adult secure mental health services as part of a pilot programme in which providers will commission these services themselves in order to improve pathways through to community care

**West Yorkshire and Harrogate**: reviewing CAMHS inpatient services in order to reduce out of area placements

**West, North and East Cumbria**: developing ‘integrated care communities’ to join up a range of primary and community services (including mental health) to meet the challenges of working in remote, rural areas

**Frimley**: creating 14 ‘integrated hubs’ to join up mental and physical health care with a single point of access

**North Central London**: including a range of measures to improve services, including developing a female PICU, specialist community eating disorder and perinatal mental health teams and extra support for abused children
Centre for Mental Health has reviewed for this project a sample of seven STPs from across the country, including some of those that have been noted by the King’s Fund to include significant content in relation to mental health. The extent of mental health coverage within the published plans is highly variable. It is barely mentioned in Nottinghamshire STP except as a footnote to other priorities. Others include a specific section on mental health as one of a number of priority areas or include mental health priorities within system-wide objective such as improving primary care or prevention and early intervention.

**West, North and East Cumbria** sets out a “whole system vision for mental health improvement” including implementing the Crisis Care Concordat, better primary care (within the new ‘integrated care communities’), greater third sector involvement and more support for recovery. It notes that Cumbria has significant gaps in mental health care (including primary care and perinatal) and particular challenges in recruiting medical staff.

The priority for mental health in **Frimley** is to integrate mental health within other workstreams, including a number of specific pledges for example to improve physical health for people with mental health problems (eg screening and smoking cessation), to improve crisis care, to integrate mental health practitioners in the new ‘hubs’ and to develop ‘psychologically informed approaches’ across the health system.

**Birmingham and Solihull** provides considerable detail about its mental health plan, with four overarching objectives (‘prevent, protect, manage, recover’) and four specific and measurable aims: eliminating adult out of area placements; reducing CAMHS inpatient admissions; increasing employment for people with mental health problems; and increasing access to treatment for children and young people.

Detailed ‘aspirations’ for mental health are also set out in **West Yorkshire and Harrogate**, including for a 75% reduction in suicides by 2020/21, a 40% fall in A&E attendances among people with mental health problems by 2020/21 and to eliminate all out of area placements by the end of 2017. Unlike other STPs, the plan provides more detailed proposals for each of six ‘places’ within the footprint, many of which are distinctive to the others.

**Surrey Heartlands** also includes a separate mental health ‘workstream’ with a number of objectives including for prevention (eg greater use of social prescribing and self-care); early intervention (including a ‘team around a practice’ in primary care); crisis care; and increasing the capability and wellbeing of the workforce.

Several of the STPs we reviewed made reference to the MH-FYFV and their intention to implement its recommendations through the plan. Frimley and Birmingham & Solihull both referred to vanguard programmes as key vehicles for implementation (of improving primary care and eliminating Out of Area Placements respectively) while Frimley and Surrey Heartlands both noted their involvement in the IAPT long-term conditions pilot programme.

This implies that while STPs represent an opportunity for greater localism, many are relying heavily on national initiatives and work programmes. And some also make use of nationally mandated targets (eg for IAPT, liaison psychiatry and first episode psychosis) to measure

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2 Birmingham and Solihull; Dorset; Frimley; Nottinghamshire; Surrey Heartlands; West, North and East Cumbria; West Yorkshire and Harrogate

3 Out of Area Placements refer to hospital admissions for people requiring acute inpatient care that need to be made outside the area covered by the Trust providing services in a locality because of a shortage of local beds
progress. But none of the STPs we reviewed identified ways in which they were preparing to implement the MH-FYFV in full and few make detailed reference to Future in Mind. Instead, most are selecting specific aspects of national policy to focus attention. And few demonstrate greater ambition, for example to go beyond national policy priorities.

The future of STPs

The recent NHS England FYFV implementation plan (2017b) sets out a significant change for STPs in which they will become ‘Sustainability and Transformation Partnerships’, reflecting an overarching aim of becoming “the biggest national move to integrated care of any western country” and creating “population-based integrated health systems”. It says:

“These partnerships are more than just the ‘wiring’ behind the scenes. They are a way of bringing together GPs, hospitals, mental health services and social care to keep people healthier for longer and integrate services around the patients who need it most. They are a forum in which health leaders can plan services that are safer and more effective because they link together hospitals so that staff and expertise are shared between them. At their best, they engage front-line clinicians in all settings to drive the real changes to the way care is delivered that they can see are needed and beneficial. And they are vehicles for making the most of each pound of public spending; for example, by sharing buildings or back office functions.”

This will see each Partnership create a board from its constituent members and ‘CCG Committees in Common’ to share commissioning responsibilities for some health services.

In some STP areas, partnerships will evolve a step further to become ‘accountable care systems’ “in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health” (NHS England 2017). And some of these will further evolve into ‘accountable care organisations’ “where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area.” This signals a very significant shift in the way health services are commissioned in England, both by enlarging the geographical footprints of decision-making and by closing the purchaser-provider split created in 1989.

The impact of devolution

In addition to STPs, devolution arrangements in England’s city regions have also brought about a renewed focus on mental health. While the primary impetus for devolution is economic, health (and particularly mental health) has had a high profile in all of the major devolved regions:

**London:** while health services are not within the Mayor’s control, the current Mayor has announced a new Thrive London initiative to raise the profile of mental health in London

**Greater Manchester:** health spending has been devolved to the combined authority, which has published a strategy for mental health and is currently determining its priorities for health and social care transformation; and the recently elected mayor Andy Burnham has made specific pledges to prioritise children’s mental health

**West Midlands:** a Commission led by Norman Lamb MP has set out a range of proposals for Thrive West Midlands including investing in IPS and Housing First, improving suicide prevention and primary care, incentivising employer engagement and supporting people in
the criminal justice system; the mayor, Andy Street, pledged to implement these proposals during his election campaign.
9. Conclusions and implications

The evidence reviewed in this report points to the conclusion that mental health services, and the people who work in them, face both widespread instability and significant opportunity in the foreseeable future. Mental health services are the focus of a great deal of attention from policymakers nationally, regionally and locally. Much of this is focused on implementing the MH-FYFV, both through the actions of ALBs and through the proposals in many STPs.

Improving mental health services was noted as one of four priorities in the recent *Next Steps for the Five Year Forward View* from NHS England (2017b) and it was the subject of a major speech (prior to the announcement of a General Election) from the Prime Minister at the start of 2017 which indicated that mental health is now a cross-government issue, not just for the Department of Health. Mental health has been identified as a priority for the Department for Work and Pensions, the Home Office, Ministry of Justice and Department for Education, among others.

But there are also signs that this prioritisation has its limits. There is continuing evidence that funds assigned to mental health care are being used to plug deficits among other NHS providers. Social care is also widely acknowledged to be under considerable financial pressures along with other local authority services relevant to mental health.

Nonetheless, there are significant opportunities for education and training resulting from both mental health policy within the NHS and from wider changes to health services. Particular areas of potential opportunity to build the capability of the workforce in mental health may include:

- The development of enhanced primary care mental health support, particularly within integrated care arrangements emerging in many localities, requiring new skills and capabilities to meet a range of needs
- The creation of new, non-medical roles in the mental health and integrated care workforce, for example nursing and physician associates and assistant practitioners, to fill gaps in existing services (such as offering physical health support in mental health services)
- The development of a range of ‘liaison’ roles for mental health specialists, offering consultancy and advice in hospitals, primary care, criminal justice and other public services
- The need for mental health training and development in non-mental health services, for example to create ‘psychologically informed’ approaches to long-term conditions and to urgent and emergency care
- The importance of delivering evidence-based interventions to ensure best value for limited resources: supporting STPs to develop staff skills relating to NICE-approved therapies and quality standards
- The need to support individuals and families in self-care, self-management and life skills; aiming to prevent problems from escalating and to enable recovery.

All of these imperatives require staff to possess a distinctive set of skills and capabilities, many of which will require new and different approaches to training, education and development. They mean that professionals need to develop knowledge in greater breadth than current training often allows (eg across mental and physical health) and to develop
skills in advising and supporting service users, families and other professionals (in a wide range of services).

This will create new career options and opportunities for some, while putting extra pressure on others, especially in times of continued austerity. Training and development will be needed to help people (from both within and outside the existing workforce) to take on emerging new roles and to build themselves fulfilling careers. And support for the wellbeing and morale of the workforce will be vital to improve quality, productivity and retention.

Notwithstanding the opportunities identified, education services need to be cognisant of the capacity pressures in the healthcare workforce and deliver education provision in light of significant staff shortages and other workforce pressures.
References


Bell A (2016) Meeting the need. London: Centre for Mental Health


Durcan G et al (2017) Meeting us where we’re at. London: Centre for Mental Health


Kaur M (2017) Tackling culture change to transform mental health services. The King’s Fund


Matthews K (2017) Supporting Carers. London: Centre for Mental Health


NHS Benchmarking Network (2013) CAMHS Benchmarking Report. Available at:
http://www.rcpsych.ac.uk/pdf/CAMHS%20Report%20Dec%202013%20v1(1).pdf


NHS Confederation (November, 2016) Key statistics on the NHS. Available at:
http://www.nhsconfed.org/resources/key-statistics-on-the-nhs

NHS Digital (2016) Number of people in contact with NHS funded adult secondary mental health and learning disability services by provider type and highest level of care, 2003/4 – 2015/16.

NHS Digital (2017a). Mental Health Services Monthly Statistics Final October, Provisional November 2016, Experimental. Available at:

http://content.digital.nhs.uk/searchcatalogue?productid=24275&returnid=1741


NHS Digital (2017d) NHS Workforce Statistics - October 2016, Provisional statistics. Available at:
http://content.digital.nhs.uk/searchcatalogue?productid=24139&returnid=1907


NHS England (2016) Implementing the Five Year Forward View for Mental Health. Available at: https://www.england.nhs.uk/mentalhealth/taskforce/imp/

NHS England (2017a) The Five Year Forward View for Mental Health: One year on. NHS England


Parsonage M and Fossey M (2012) Liaison psychiatry in the modern NHS. London: Centre for Mental Health

Royal College of Nursing (2016) cited in The Guardian. Number of nurses falls by 10%. Available at: https://www.theguardian.com/society/2016/jan/25/number-of-mental-health-nurses-falls-10