THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

A report from the independent Mental Health Taskforce to the NHS in England
February 2016

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FOREWORD

For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.

But in recent years, the picture has started to change. Public attitudes towards mental health are improving, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it. There is now a cross-party, cross-society consensus on what needs to change and a real desire to shift towards prevention and transform NHS care.

This independent report of the Mental Health Taskforce sets out the start of a ten year journey for that transformation, commissioned by Simon Stevens on behalf of the NHS. We have placed the experience of people with mental health problems at the heart of it. Over 20,000 people told us of the changes they wanted to see so that they could fulfil their life ambitions and take their places as equal citizens in our society. They told us that their priorities were prevention, access, integration, quality and a positive experience of care. Their voices are quoted in this report and their views are reflected in our recommendations.

First, we have made a set of recommendations for the six NHS arm's length bodies to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people.

Second, we set out recommendations where wider action is needed. Many people told us that, as well as access to good quality mental health care wherever they are seen in the NHS, their main ambition was to have a decent place to live, a job or good quality relationships in their local communities. Making this happen will require a cross-government approach.

Finally, we have placed a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level.

We want to thank all the Taskforce members, and the tens of thousands of people who contributed to and helped to co-produce this report.

Paul Farmer, Chair

Jacqui Dyer, Vice-Chair

EXECUTIVE SUMMARY

THE CURRENT STATE OF MENTAL HEALTH

"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. **One in four adults** experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.

POLICY CONTEXT

There has been a **transformation in mental health** over the last 50 years. Advances in care, the development of anti-psychotic and mood stabilising drugs, and greater emphasis on human rights led to the growth of community based mental health services. In the 1990s, the Care Programme Approach was developed to provide more intensive support to people with severe and enduring mental illness. There was a new emphasis on promoting public mental health and developing services for children and homeless people. In 1999, the National Service Framework for Mental Health was launched to establish a comprehensive evidence based service. This was followed by the NHS Plan in 2000 which set targets and provided funding to make the Framework a reality. A National Service Framework for Children, Young People and Maternity Services was then launched in 2004.

In 2011, the Coalition government published a **mental health strategy** setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. The strategy was widely welcomed. However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives.

Yet, over the last five years, public attitudes towards mental health have improved, in part due to the Time to Change campaign. In turn, this increased awareness has heightened understanding of an urgent need to act on improving the experiences of people with mental health problems, both within and beyond the NHS. There is now a need to **re-energise and improve mental health care across the NHS** to meet increased demand and improve outcomes.

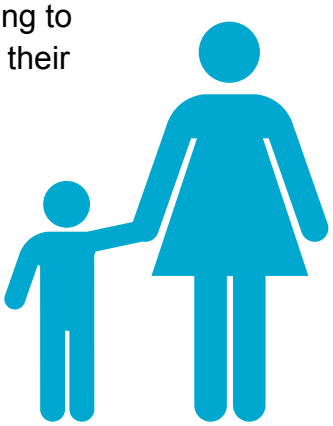
In this context, NHS England and the Department of Health **published Future in Mind** in 2015, which articulated a clear consensus about the way in which we can make it easier for children and young people to access high quality mental health care when they need it. This strategy builds on these strong foundations.

Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond.

MENTAL HEALTH PROBLEMS IN THE POPULATION

Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. **One in ten children** aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison. Yet most children and young people get no support. Even for those that do the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16. A small group need inpatient services but, owing to inequity in provision, they may be sent anywhere in the country, requiring their families to travel long distances.

1 IN 10 CHILDREN AGED 5-16 YEARS HAVE A DIAGNOSABLE MENTAL HEALTH PROBLEM



One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have long-standing effects on children's emotional, social and cognitive development. Costs of perinatal mental ill health are estimated at £8.1 billion for each annual birth cohort, or almost £10,000 per birth. Yet fewer than 15 per cent of localities provide effective specialist community perinatal services for women with severe or complex conditions, and more than 40 per cent provide no service at all.

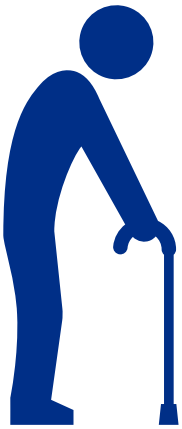
Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people** – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

In addition, **people with long term physical illnesses suffer more complications if they also develop mental health problems,** increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.

Stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Between 60–70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.

Only **half of veterans of the armed forces** experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. NHS England is currently consulting on the future of mental health support for this group and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.



40 PER CENT OF OLDER PEOPLE LIVING IN CARE HOMES ARE AFFECTED BY DEPRESSION

People in **marginalised groups** are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.

People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.

As many as **nine out of ten people in prison** have a mental health, drug or alcohol problem.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death.

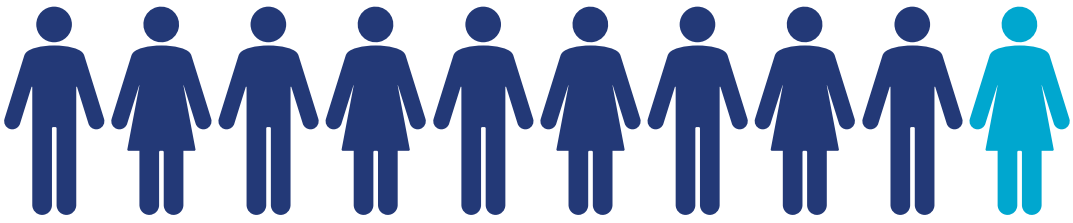
More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides amongst inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

CURRENT EXPERIENCES OF MENTAL HEALTH CARE

Nearly two million adults were in contact with **specialist mental health and learning disability services** at some point in 2014/15 – though we know little about the quality of their care and there remains extensive unmet need for mental health care. Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). However, there is considerable variation in services, with a waiting time of just over six days in the best performing areas and 124 days in the worst performing areas in 2014-15.

Of those adults with more **severe mental health problems** 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions. One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.



NINE OUT OF TEN ADULTS WITH MENTAL HEALTH PROBLEMS ARE SUPPORTED IN PRIMARY CARE

In its recent review of **crisis care**, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police. The inquiry found that while adults were seen promptly where liaison mental health services were available in an A&E department and there were clear pathways through to community services, those aged under 16 were referred directly to children and young people's services but seen only when services were open during office hours. This could involve waiting a full weekend and lead to a significant variation in the quality of care on the basis of someone's age.

Admissions to **inpatient care** have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.

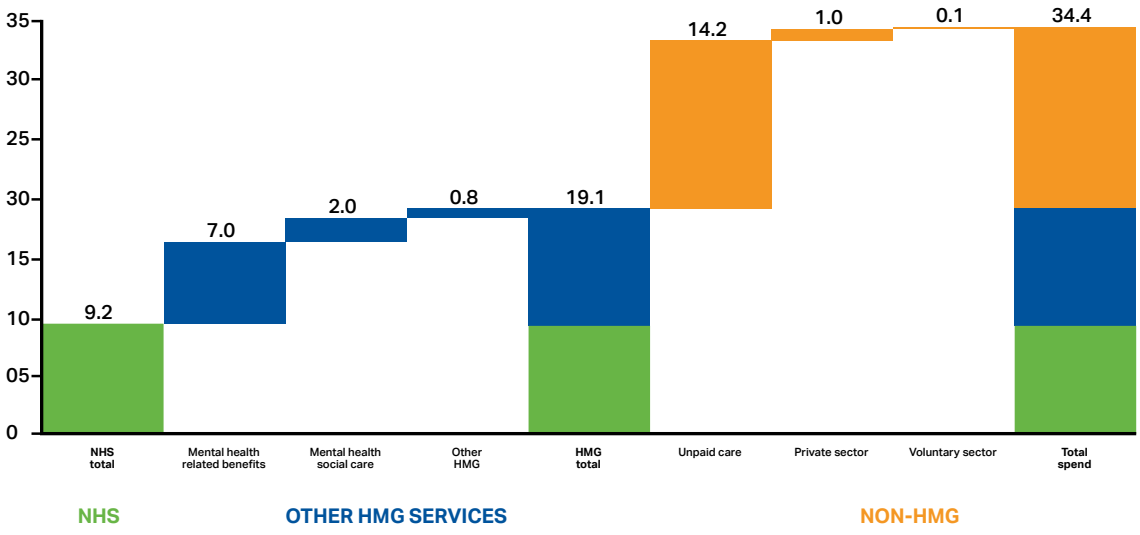
The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. For children and young people, average admissions per provider increased from 94 in 2013/14 to 106 in 2014/15. **Bed occupancy** has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances **outside of their area**.

Mental health accounts for 23 per cent of NHS activity but NHS **spending** on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.

£34 BILLION EACH YEAR SPENT ON MENTAL HEALTH

Poor mental health carries an **economic and social cost of £105 billion a year** in England. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use [1].

Total cost of mental health support and services in England 2013/14 (£bn)



Note: this analysis aims to capture direct spend on services provided to support those with mental ill-health; it does not factor in second-order costs in other public services or wider society Source: Programme Budgeting, Departments' finance data, HSCIC, DWP spend on benefits

£19 billion of this is made up of government spend, though there is little or no national data available for how up to 67 per cent of mental health funding is used at a local level. Most of the remainder (£14bn) is for the support provided by unpaid carers, plus a relatively small share that is funded through the private and voluntary sectors.

Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be **re-invested to meet the significant unmet mental health needs** of people of all ages across England, and to improve their experiences and outcomes.

[1] NHS England internal analysis

WHAT NEEDS TO HAPPEN - A FRESH MINDSET

"We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need provision of mental health support in physical health care settings - especially primary care."

People told us that their mental health needs should be treated with equal importance to their physical health needs, whatever NHS service they are using – this is a fundamental principle of the Taskforce recommendations.

All too often people living with mental health problems still experience stigma and discrimination, many people struggle to get the right help at the right time and evidence-based care is significantly underfunded. The human cost is unacceptable and the financial cost to government and society is unsustainable.

Leaders across the system must take decisive steps to break down barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, drive down variations in the quality of care on offer, and improve outcomes.

Our ambition is to deliver rapid improvements in outcomes by 2020//21 through ensuring that 1 million more people with mental health problems are accessing high quality care. In the context of a challenging Spending Review, **we have identified the need to invest an additional £1 billion in 2020/21**, which will generate significant savings. It builds on the £280 million investment each year already committed to drive improvements in children and young people's mental health, and perinatal care.

PRIORITY ACTIONS FOR THE NHS BY 2020/21

1. A 7 day NHS – right care, right time, right quality

"If you feel unwell in the evening, during the night or at the weekends and bank holidays there is no choice but to go to A&E. There's no support out there during these times. It's crucial that this is changed for the benefit of service users, their families and carers."

People facing a crisis should have access to mental health care **7 days a week** and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work. Early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs.

The Care Quality Commission (CQC) found that just half of Community Mental Health Teams (CMHTs) are able to offer a 24/7 crisis service today. By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme. **Out of area placements for acute care should be reduced and eliminated as quickly as possible.**

Good liaison mental health care is also needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a minority of A&E departments have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am. By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum.

People experiencing a first episode of psychosis should have access to a NICE-approved care package within 2 weeks of referral. Delay in providing care can lead to poorer clinical and social outcomes. The NHS should ensure that by April 2016 more than 50 per cent of this group have access to Early Intervention in Psychosis services, rising to at least 60 per cent by 2020/21.

People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. **The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible.**

More ‘step-down’ help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams. By April 2017, population-based budgets should be in place for those CCGs who wish to commission specialised services for people of all ages, in partnership with local government and national specialised commissioners. The Taskforce welcomes the invitation set out in NHS England Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve full community and inpatient care pathways.

A 7 DAY CRISIS RESPONSE SERVICE WILL HELP SAVE LIVES

Improving the 7 day crisis response service across the NHS will help save lives as part of a major drive to **reduce suicide by 10 per cent by 2020/21.** Every area must develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population.

Some people experience unacceptably poor access to or quality of care. There has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme in 2010. **Inequalities in access** to early intervention and crisis care, rates of detentions under the Mental Health Act 1983 and lengths of stay in secure services persist.

National and local commissioners must show leadership in tackling unwarranted variations in care. The Department of Health should address race equality as a priority and appoint a new equalities champion to drive change.

Measures must be taken to ensure all deaths across NHS-funded inpatient mental health services are properly investigated, and learned from to improve services and prevent repeat events. By April 2017, the Department of Health should establish an independent system for the assurance of the quality of investigations of all deaths in inpatient mental health services and to ensure a national approach to applying learning to service improvement.

2. An integrated mental and physical health approach

"Making physical and mental health care equally important means that someone with a disability or health problem won't just have that treated, they will also be offered advice and help to ensure their recovery is as smooth as possible, or in the case of physical illness a person cannot recover from, more should be done for their mental wellbeing as this is a huge part of learning to cope or manage a physical illness."

People told us that mental health support should be made easily available across the NHS - for mums to be, children, young adults visiting their GP, people worried about stress at work, older people with long-term physical conditions and people receiving care for cancer or diabetes.

People with existing mental health problems told us that services should be integrated - for example, physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness.

The impact of mental health problems experienced by women in pregnancy and during the first year following the birth of their child can be devastating for both mother and baby, as well as their families. **By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.** This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met. They should be offered screening and secondary prevention reflecting their higher risk of poor physical health. This will reduce the health inequalities gap. We know there is low take up of information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer. In England there are over 490,000 people with severe mental illness registered with a GP. The proportion receiving an annual physical health check ranges from 62 per cent to 82 per cent (this data does not include any information about how many people are being supported to access evidence based interventions as a result of these checks). People with a long standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018.

The provision of psychological therapies for people with common mental health problems has expanded hugely in recent years. But it is still meeting only 15 per cent of need for adults. NHS England should **increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21.** There should be a focus on helping people who are living with long-term physical health conditions or who are unemployed. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

PEOPLE WITH A LONG STANDING MENTAL HEALTH PROBLEM ARE TWICE AS LIKELY TO SMOKE

3. Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

"If I'd had the help in my teens that I finally got in my thirties, I wouldn't have lost my twenties."

Prevention matters - it's the only way that lasting change can be achieved. Helping people lead fulfilled, productive lives is not the remit of the NHS alone. It involves good parenting and school support during the early years, decent housing, good work, supportive communities and the opportunity to forge satisfying relationships. These span across national and local government, so the Taskforce has a set of recommendations to build on the Prime Minister's commitment to a "mental health revolution."

Prevention at key moments in life

Children and young people are a priority group for mental health promotion and prevention, and we are calling for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care.

By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it. This will require a fundamental change in the way services are commissioned, placing greater emphasis on prevention, early identification and evidence-based care. NHS England should continue to work with partners to fund and implement the whole system approach described in Future in Mind, building capacity and capability across the system so that by 2020/21 we will secure measurable improvements in children and young people's mental health outcomes. We need to ensure that good quality local transformation

plans are put into action, invest in training to ensure that all those working with children and young people can identify mental health problems and know what to do, complete the roll-out of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme across England by 2018 and develop an access standard for Child and Adolescent Mental Health Services (CAMHS) by the end of 2016/17. This should build on the standard for children and young people with eating disorders announced in July 2015.

BY 2020/21 AT LEAST 70,000 MORE CHILDREN AND YOUNG PEOPLE SHOULD HAVE ACCESS TO HIGH-QUALITY MENTAL HEALTH CARE

In addition, some children are particularly vulnerable to developing mental health problems - including those who are looked after or adopted, care leavers, victims of abuse or exploitation, those with disabilities or long term conditions, or who are within the justice system. The Departments of Health and Education should establish an expert group to examine their complex needs and how they should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People's mental health services.

The **employment rate for adults** with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population and 65 per cent of people with other health conditions. Of people with 'mental and behavioural disorders' supported by the Work Programme, only 9.5 per cent have been supported into employment, a lower proportion than for some proven programmes. There is a 65 per cent point gap between the employment rates of people being supported by specialist mental health services who have more severe health problems and the general population.

Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed.

By 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).

Employment is vital to health and should be recognised as a health outcome. The NHS must play a greater role in supporting people to find or keep a job. Access to psychological support must be expanded to reach at least a quarter of all people who need it. There must be a doubling of access to Individual Placement and Support programmes to reach an extra 30,000 people living with severe mental illness (so that at least 9,000 are in employment), and the new Work and Health Programme should prioritise investment in health-led interventions that are proven to work for people with mental health problems.

JUST 43%
OF PEOPLE WITH MENTAL HEALTH PROBLEMS ARE IN EMPLOYMENT

Creating mentally healthy communities

We heard from many people about the importance of the role of Local Government in the promotion and prevention agenda. Building on the success of local Crisis Care Concordat Plans, we recommend the creation of local Mental Health Prevention Plans, based on high quality evidence.

Housing is critical to the prevention of mental health problems and the promotion of recovery. The Department of Health, the Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

In relation to the proposed Housing Benefit cap to Local Housing Allowance levels, the Department of Work and Pensions should use evidence to ensure that the right levels of protection are in place for people with mental health problems who require specialist supported housing. The Ministry of Justice, Home Office, Department of Health, NHS England and Public Health England should work together to **support those in the criminal justice system experiencing mental health problems** by expanding- liaison and diversion schemes nationally, increasing support for Blue Light services, and for the 90 per cent of people in prison with mental health problems, drug or alcohol problems.

Ending the **stigma** around mental ill health is vital. The Department of Health and Public Health England should continue to help local communities build a grass roots social movement to raise awareness of good physical and mental health and support people to seek help when they need it.

Building a better future

"There should be even greater emphasis put on people's experience and how experts-by-experience can be seen as real assets to design and develop services."

The next five years will build the foundations for the next generation.

The UK should be a world leader in the development and application of new **mental health research**. The Department of Health, working with relevant partners, should publish a ten year strategy for mental health research one year from now including a co-ordinated plan for strengthening the research pipeline on identified priorities, and promoting implementation of research evidence.

A **data and transparency revolution** is required to ensure greater consistency in the availability and quality of NHS-funded services across the country. The information gathered by the NHS should reflect social as well as clinical outcomes – e.g. education, employment and housing - that matter to people with mental health problems. This requires better data linkage across the NHS, public health, education and other sectors, with absolute transparency on spending in relation to prevalence, access, experience and outcomes. **By 2020/21, CCGs should be required to publish a range of benchmarking data to provide transparency about mental health spending and performance.**

DELIVERING THIS STRATEGY

"Being both a junior doctor training in psychiatry, and a patient with mental health problems, enables me to experience both sides of the NHS, and I feel this gives me a great advantage and insight. Whilst a lot of the work I experience on both sides is very positive, I am frequently amazed by the heavy workloads of my colleagues and those treating me. And I know that for me, this can in fact contribute to deterioration in my own mental health."

Mental health services have been chronically underfunded. We know that the presence of poor mental health can drive a 50 per cent increase in costs in physical care. The Taskforce considers it a point of basic parity between physical and mental health that types of care and therapies shown to lead to improved mental health outcomes and found to be cost-effective should be made available to people with mental health problems. Without upfront investment it will not be possible to implement this strategy and deliver much-needed improvements to people's lives, as well as savings to the public purse.

£1 BILLION
ADDITIONAL INVESTMENT NEEDED

Over the next five years additional funding should allow NHS England to expand access to effective interventions. The priority areas we have identified would require an additional £1 billion investment in 2020/21, which will contribute to plugging critical gaps in the care the NHS is currently unable to provide. Our expectation is that savings and efficiencies generated by improved mental health care e.g. through a strengthened approach to prevention and early intervention, and through new models of care, will be re-invested in mental health services.

To deliver these commitments and realise the associated savings NHS England must be able to target investment and ensure there is sufficient transparency and accountability for putting them into action. Both the current Mandate priorities and those set out in this report should specifically be reflected in the local Sustainability and Transformation plans that areas will need to produce by June 2016, in how those plans are assessed and in the processes for allocating and assuring funds.
We recommend eight principles to underpin reform:

- Decisions must be locally led
- Care must be based on the best available evidence

- Services must be designed in partnership with people who have mental health problems and with carers
- Inequalities must be reduced to ensure all needs are met, across all ages
- Care must be integrated – spanning people's physical, mental and social needs
- Prevention and early intervention must be prioritised
- Care must be safe, effective and personal, and delivered in the least restrictive setting
- The right data must be collected and used to drive and evaluate progress

We make specific recommendations on the need to develop and support the mental health workforce, making it a career option of choice across medicine, social care, the allied health professions and the voluntary sector. We encourage the further development of personalised care, giving people choice in their own care, and the expansion of peer support.

We make a series of fundamental recommendations to hardwire mental health into how care is commissioned, funded, and inspected, across the whole NHS. These should enable mental health to be fully embedded in NHS planning and operations for the duration of the Five Year Forward View.

Co-production with experts-by-experience should also be a standard approach to commissioning and service design, with Arm's Length Bodies (ALBs) leading by example and supporting this practice in local areas. We recommend the creation of a Mental Health Advisory Board reporting to the Five Year Forward View Board, publicly updating on progress against our recommended outcomes. We also encourage the Cabinet Office and Department of Health to put in place cross-government oversight of the wider actions we are recommending the Government should take, in addition to those being led by the NHS.

Conclusion

A summary of our recommendations can be found in the second annex of this report. Delivery of these recommendations is everybody's business - for the NHS, for health and social care professionals, for providers, employers, across government and communities.

But the critical element of success will be to put the individual with their own lived experience of mental health at the heart of each and every decision which is made. We have much to be proud of in the progress that has been made in empowering people to make their own decisions, and for services to be co-designed. We now have to go a step further and truly produce services which are led by the needs of the individual, not the system.

CHAPTER ONE:

GETTING THE FOUNDATIONS RIGHT: COMMISSIONING FOR PREVENTION AND QUALITY CARE

Every person with a mental health problem should be able to say:
I am confident that the services I may use have been designed in partnership with people who have relevant lived experience.

People with lived experience of mental health problems, carers and health and social care professionals told the Taskforce that prevention was a top priority. Specific themes raised included support for new mothers and babies, mental health promotion within schools and workplaces, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing, and getting help early to stop mental health problems escalating. Many people discussed the importance of addressing the wider determinants of mental health, such as good quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement. It was suggested that while it is particularly important to recognise loneliness in older people, these issues can affect people of any age.

1.1 THE SYSTEM NOW

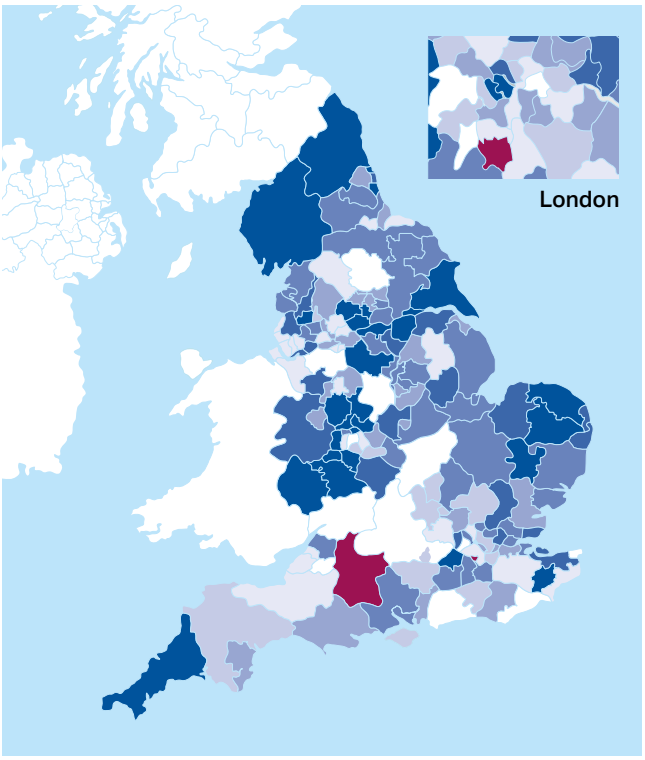
The quality of local mental health commissioning is variable. We found a twofold difference in apparent per-capita spend by CCGs, a more than threefold difference in excess premature mortality in people with mental health problems in England and a fourfold variation in mortality across local authorities. For children and young people there is wide variation in spend in both the NHS and local authorities. Detentions under the Mental Health Act continue to rise

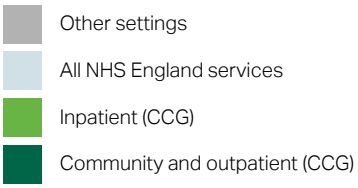
steadily year on year. Similarly, we know that many adults cannot get the right care locally, a clear demonstration of poor quality commissioning and a lack of investment to meet local need. Reductions in local authority budgets are also leading to rising pressures on important components of mental health care e.g. social care and residential housing.

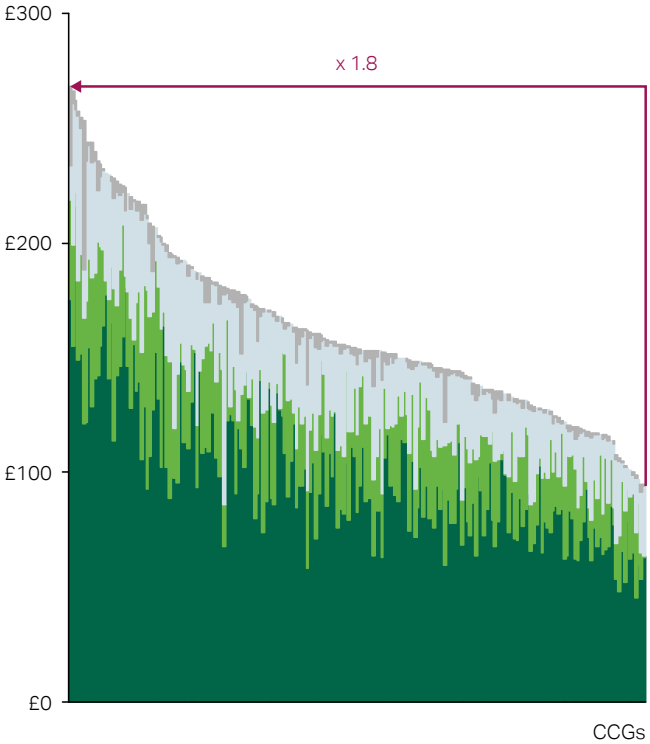
Up to ~2x variation in per-capita spend, even when adjusted

Unadjusted spend shows 5x variation

Spend per PRAMH-weighted capita by CCGs and NHS England on mental health 2013/14
PRAMH model weights the population based on age, sex, prevalence of mental health conditions, markers of severity (e.g. MHA), accommodation and employment status, ethnicity and length of contact with mental health services







Note: Excludes 2 CCG; NHS England per capita expenditure varies by four regions (not by CCG). Source: Programme Budgeting 2013/14; Specialised Finance data; NHS England PRAMH weighted population

Commissioning of services is fragmented between CCGs, local authorities and the NHS. More needs to be done on prevention to reduce inequalities and there needs to be a greater focus on preventing suicide. There is increasing interest in “population-based” commissioning, either by pooling budgets or through joint decision-making with other commissioners, and a number of places are combining spending power across health and social care. The use of personal health budgets is increasing and other new models of care are being developed.

However, there is a long way to go to achieve integrated, population-based commissioning that is crucial for improving mental health outcomes, and incorporates specialised commissioning.

The Crisis Care Concordat action plans are promising as a model for integrated local commissioning. We also endorse the approach set out in Future in Mind as a model for wider system reform, which involves the NHS, public health, voluntary, local authority, education and youth justice services working together through Local Transformation Plans to build resilience, promote good mental health and make it easier for children and young people to access high quality care. This builds on a range of existing legislation that concerns children and young people and which requires agencies to take a coordinated approach. The plans are also important because they address the full spectrum of need, including children and young people who have a particular vulnerability to mental health problems.

Challenges remain to breaking down barriers between how services are commissioned across the country. Within the NHS, primary, secondary and tertiary care services should deliver integrated physical and mental health outcomes. Currently needs are addressed in isolation, if at all, which is not effective or efficient. CCGs need to ensure people with multiple needs do not fall through service gaps. For example, the commissioning of alcohol and substance misuse services has been transferred from the NHS to local authorities, leading to the closure of specialist NHS addiction inpatient units. Referral pathways have become more complex and many people with mental health and substance misuse problems no longer receive planned, holistic care.

On employment, the Department of Work and Pensions forecasts that it will spend £2.8 billion in total payments to contractors to help people into work under the Work Programme between June 2011 and March 2020. Yet fewer than one in 10 people with mental health problems have gained employment through the Work Programme. We know psychological therapies and Individual Placement and Support (IPS) services have proved highly effective – with around 30 per cent moving into jobs through IPS – but these are not being commissioned at scale. The Taskforce also welcomes the introduction of a Joint Unit for Work and Health, which is already piloting new approaches and recently secured significant new investment for an innovation fund.

Commissioners need support to analyse data, moderate demand, channel individuals to appropriate care and test their use of resources against their priorities. Co-production with clinicians and experts-by-experience to ensure services are accessible and appropriate for people of all backgrounds is also essential. Commissioners also need to understand what works, be adept at the use of financial and other levers, and be fully accountable for improving the mental health of their communities.

1.2 THE SYSTEM IN THE FUTURE

Local communities will be supported to develop effective Mental Health Prevention plans, and use the best data available to commission the right mix of services to meet local needs. Plans should focus on public mental health, including promoting good mental health, addressing the wider social determinants of mental health problems, local approaches to challenging stigma, and targeting at risk groups with proven interventions. This approach should blend healthcare, social care and user-led support.

By 2020/21, NHS commissioning will be underpinned by a robust understanding of the mental health needs of the local population, bringing together local partners across health, social care, housing, education, criminal justice and other agencies, with a clear recognition of the mental health needs of people treated for physical ailments and vice versa, and with greater integration across agencies to build stronger, more resilient communities. Commissioners will have the knowledge and skills to embed what is proven to work, and to work in partnership with people using services, carers, and local communities to develop and evaluate innovative new models in a range of settings.

The quality of services and outcomes will be assessed on the basis of robust data. There will be clear plans in place to prevent mental ill-health and suicide. More areas will have the freedom to work jointly across whole health and social care systems, following the examples of Manchester and West Midlands.

The Taskforce welcomes the invitation set out in NHS England Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve care pathways. This is a significant change, which should be developed as a new vanguard programme, ensuring adequate inpatient resource is maintained while preparations are made to support people who are ready to transition into community based services. NHS England should also have established new models of care to trial this new approach for perinatal and CAMHS inpatient services.

Commissioners will:

- work in partnership with local stakeholders and voluntary organisations
- co-produce with clinicians, experts-by-experience and carers
- consider mental and physical health needs
- plan for effective transitions between services
- enable integration
- draw on the best evidence, quality standards and NICE guidelines
- make use of financial incentives to improve quality
- emphasise early intervention, choice and personalisation and recovery
- ensure services are provided with humanity, dignity and respect.

1.3 THE DELIVERY PLAN BY 2020/21

Health and Wellbeing Boards should have plans in place to promote good mental health, prevent problems arising and improve mental health services, based on detailed local data for risk factors, protective factors and levels of unmet need. These should specifically identify which groups are affected by inequalities related to poor mental health and be co-produced with local communities to generate innovative approaches to care and improving quality. Each local council should have Mental Health Champions, building on the 60 that already exist. Nationally, the Department of Health should lead continued work to tackle stigma.

Co-production with clinicians and experts-by-experience should also be at the heart of commissioning and service design, and involve working in partnership with voluntary and community sector organisations. Applying the 4PI framework of Principles, Purpose, Presence, Process and Impact developed by the National Survivor and User Network will help ensure services or interventions are accessible and appropriate for people of all backgrounds, ages and experience.

We expect rapid progress in the transformation of services for children and young people following investment of £1.4 billion over five years announced by the Government in 2014/15 (including additional money for eating disorders in children and young people). Plans are ready and these will be the first major programmes set out in this strategy to be delivered.

More people with common mental health problems should be supported into work through expanding integrated access to psychological therapies and employment support in primary care. Thousands more people accessing secondary mental health services should also be supported to find or keep a job through evidence based Individual Placement and Support services.

The NHS, local authorities, housing providers and other agencies should be working together locally to increase access to supported housing for vulnerable people with mental health problems. They should also be acting to share joint

plans and information between local partners so that mainstream housing services play a more active role in preventing mental health problems arising.

While joint working between the CCG commissioners and other partners has been accepted for children and young people, further work is required across adult services. This offers a means of tackling the difficulties arising from the fracturing of commissioning pathways and escalating demand for inpatient services. Work is also required across secure services and the criminal justice system.

These are the opportunities – but there are also risks. There will be uncertainty about the role and function of commissioning as local geographies change, responsibilities shift, and budgets come under pressure. NHS England and the ALBs must be clear what they expect of commissioners and ensure they are supported.

The transformation we envisage will take a number of years and without clear information about what the best care pathways look like and good data on current levels of spending, access, quality and outcomes, it will be hard to assess the impact of organisational change and ensure mental health services are not disadvantaged. Priority should also be given to tackling inequalities and routine data must be made available so that there is transparency about how local areas are addressing age, gender, ethnicity, disability and sexuality in their plans.

We recognise that the new models of care will not be operating nationwide by 2020/21. Providers currently carry much of the risk and responsibility for improvements in quality and outcomes, with too little scrutiny of commissioning. In an increasingly devolved system, commissioners must remain responsible for meeting the needs of their local populations and must be properly held to account.

Recommendation 1: NHS England should continue to work with Health Education England (HEE), Public Health England (PHE), Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping 70,000 more children and young people to access high quality mental health care when they need it. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.

Recommendation 2: PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated Joint Strategic Needs Assessment (JSNA) and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.

Recommendation 3: The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, reviewed annually thereafter and supported by new investment.

Recommendation 4: The Cabinet Office should ensure that the new Life Chances Fund of up to £30 million for outcome-based interventions to tackle alcoholism and drug addiction through proven approaches requires local areas to demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.

Recommendation 5: By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see Chapter Two) and doubling the reach of Individual Placement and Support (IPS). The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.

Recommendation 6: The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).

Recommendation 7: The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts.

Recommendation 8: NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.

Recommendation 9: NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17, NHS England should also trial new models through a vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements.

Recommendation 10: The Department of Health, Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

Recommendation 11: The Department of Work and Pensions should, based on the outcome of the "Supported Housing" review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.

Recommendation 12: The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community to contribute towards improving attitudes to mental health by at least a further 5 per cent by 2020/21.

CHAPTER TWO:

GOOD QUALITY CARE FOR ALL 7 DAYS A WEEK

Every person with a mental health problem should be able to say:
I have rapid access, within a guaranteed time, to effective, personalised care. I have a choice of talking therapy so that I can find one appropriate to me. When I need urgent help to avoid a crisis I, and people close to me, know who to contact at any time. People take me seriously and trust my judgement when I say a crisis is approaching. I can get help in a crisis, fast. Where I raise my physical health concerns, in any setting, they are taken seriously and acted on. If I am in hospital, staff on the wards can help with my mental as well as physical health needs. Services understand the importance to me of having friends, opportunities and close relationships.

The Taskforce heard that timely access to effective, good quality, evidence-based mental health pathways, with clear waiting times, is a primary concern. People also value having a choice of support, tailored to their specific needs, including access to a full range of psychological therapies. Access to treatment should be equal, and care should support people of all ages, regardless of the particular mental health problem they experience.

2.1 THE SYSTEM NOW

People who need physical health care – cancer care, for example – know what to expect and when to expect it. There are clear pathways of care, quality standards and maximum waiting times.

This is not always true of mental health care. Even though we know that the right care delivered in the right way at the right time improves and may save lives, mental health care has not benefited from the clear pathways and standards in place for secondary physical health care. Models of primary mental health care are also under-developed, and people with mental health problems are not always well supported in primary care with either their mental or physical health care needs.

The introduction of the first access and quality standards for mental health services therefore represents an important step forwards. Access to psychological therapies for common conditions such as anxiety and depression, as recommended by NICE, has increased. Work is in progress to improve services for people experiencing a first episode of psychosis, in perinatal care, crisis care and in children and young people's services, including for those with eating disorders.

What is lacking is a comprehensive set of standards – comparable to those for physical health care – and the supporting quality and outcomes data showing what works. Combined with under-investment, most people receive currently no effective care and too few benefit from the full range of NICE-recommended interventions.

Waiting times – for first appointments and for the right follow-on support – are unacceptably long. Basic interventions are in short supply, services are under pressure and thresholds for access are being raised. As a result, people's needs often escalate and they can become acutely unwell or experience a crisis, resulting in poorer outcomes and a reliance on higher cost care.

Crisis care is improving following the signing of the Crisis Care Concordat – but there is still a long way to go to match standards in urgent and emergency care for physical health needs. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, reported that the current reliance on acute beds means that it is often difficult for people to access care near home and that this is exacerbated by a lack of community services, particularly Crisis Response and Home Treatment Teams (CRHTTs). Only 14 per cent of adults experiencing a crisis feel they are provided with the right response and just over one third (36 per cent) feel respected by staff when they attend A&E. Less than half (48 per cent) of children and young people's services have a crisis intervention team. Too often people in crisis end up in a police cell rather than a suitable alternative place of safety.

Adult mental health services are under intense pressure. Less than half of CRHTTs have sufficient staff to provide 24/7 intensive home treatment as an alternative to admission, putting extra pressure on hospital beds. Delayed discharge and transfers of care are as high as 38 per cent in some areas, often linked to a lack of suitable housing or social care. Bed occupancy routinely exceeds 95 per cent and the CQC 'Right Here, Right Now' report found that many people have to travel long distances to be admitted.

Comprehensive liaison mental health services are currently available in only one in six (16 per cent) of England's 179 acute hospitals. The situation is better for paediatric mental health liaison, with 79 per cent of hospitals reporting cover, but these frequently do not operate out of hours.

Long stays in high cost secure hospitals and delayed discharge are common, often owing to the lack of recovery-focused care and suitable “step-down” services. Nine out of ten people in prison have a mental health or substance abuse problem – often together – but most do not receive the right care.

Some groups are disproportionately represented in detentions to acute and secure inpatient services, and are affected by long stays. For example, men of African Caribbean ethnic origin are twice as likely to be detained in low secure services than men of white British origin and stay for twice as long in those services on average. This suggests a failure to ensure equal access to earlier intervention and crisis care services.

Older people’s needs are also neglected, with many led to believe depression is a normal part of ageing.

People with mental health problems often also receive poorer physical health care. Those with severe mental illness die on average 15-20 years earlier than the general population. They are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary care they are receiving. The reverse is also true – people with long term physical health conditions do not routinely have mental health support included in their care package.

2.2 THE FUTURE: RIGHT CARE, RIGHT TIME, RIGHT QUALITY – 7 DAYS A WEEK

People with mental health problems, regardless of their age, ethnicity, or any other characteristic will have swift access to holistic, integrated and evidence-based care for the biological, psychological and social issues related to their needs, in the least restrictive setting and as close to home as possible.

By 2020/21, there will be a comprehensive set of care pathways in place and we expect at least a million more people will be able to get the help they need, improving outcomes and reducing reliance on acute care services. Services will provide clear data about access and waiting times and payment will be linked to the interventions delivered and the outcomes achieved.

There will be a 7 day NHS providing urgent and emergency mental health crisis care 24 hours a day, as there is for physical health, delivering 24/7 intensive home treatment and not just crisis assessment. Police cells will be used only in exceptional circumstances for people detained under the Mental Health Act. Good quality liaison mental health services will be available more widely across the country.

Mental and physical health support will be integrated. People with severe mental illness at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care. Mental health services will be delivered by multi-disciplinary integrated teams, with named, accountable clinicians, across primary, secondary and social care. They will include provision of care for substance misuse issues.

People with acute mental health needs will be able to access appropriate care, as inpatients or through community teams. Their housing, social care and other needs will be assessed on admission and the right support made available on discharge. Use of the Mental Health Act will be monitored, with a focus on Black and Minority Ethnic (BAME) groups.

People in the criminal justice system will also have their mental health needs assessed and the right care provided.

2.3 A DELIVERY PLAN FOR A 7 DAY MENTAL HEALTH SERVICE

Clinical standards, including maximum waiting times for NICE-recommended care based on the ambitions set out in Achieving Better Access to Mental Health Services by 2020/21 and the Five Year Forward View, should be rolled out nationwide. These must ensure that:

- waiting times are informed by clinical evidence and should be for effective care in line with NICE recommendations
- all services should routinely collect and publish outcomes data.

These are already in place for psychological therapies for common mental health problems, a waiting time standard for early intervention in psychosis will come into effect from April 2016 and one for children and young people with eating disorders the following year.

Urgent work is needed to establish comprehensive pathways and quality standards for the rest of the mental health system based on the timetable on page 36, which can then be implemented as funding becomes available. This programme must be co-produced with clinical experts and experts-by-experience. Work is already in happening to secure input on what robust standards for children and young people, crisis care for people of all ages, and perinatal care should look like. There should also be a referral to treatment access standard for acute care, including quality standards and outcomes measures for home treatment and inpatient care for people with acute mental health needs.

Where evidence about the effectiveness of interventions is robust and pathways are in place or are being developed there is a strong case for NHS England to invest to expand access. NHS England, the Department of Health and the Ministry of Justice should also start joint work to develop pathways across the criminal justice system.

Improved access to high quality inpatient services for children, young people and adults is needed, as highlighted by the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists which reported earlier this month.

Primary care (including Out of Hours services) should form a part of each of the relevant pathways within the new programme. There should also be a new focus in primary care on the physical health care of people with severe mental health problems, including psychosis, bipolar disorder and personality disorder.

Wherever it is provided care should be appropriate to people of all ages. Older people should be able to access services that meet their needs – bespoke older adult services should be the preferred model until general adult mental health services can be shown to provide age appropriate care.

Recommendation 13: By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, based on the timetable set out in this report. These standards should incorporate the relevant physical health care interventions and the principles of co-produced care planning.

Recommendation 14: NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting 20,000 people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

Recommendation 15: By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high quality services are in place across England.

Recommendation 16: The NHS should ensure that from April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.

Recommendation 17: By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme.

Recommendation 18: By 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the 'core 24' service standard as a minimum.

Recommendation19: NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

Recommendation 20: PHE should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

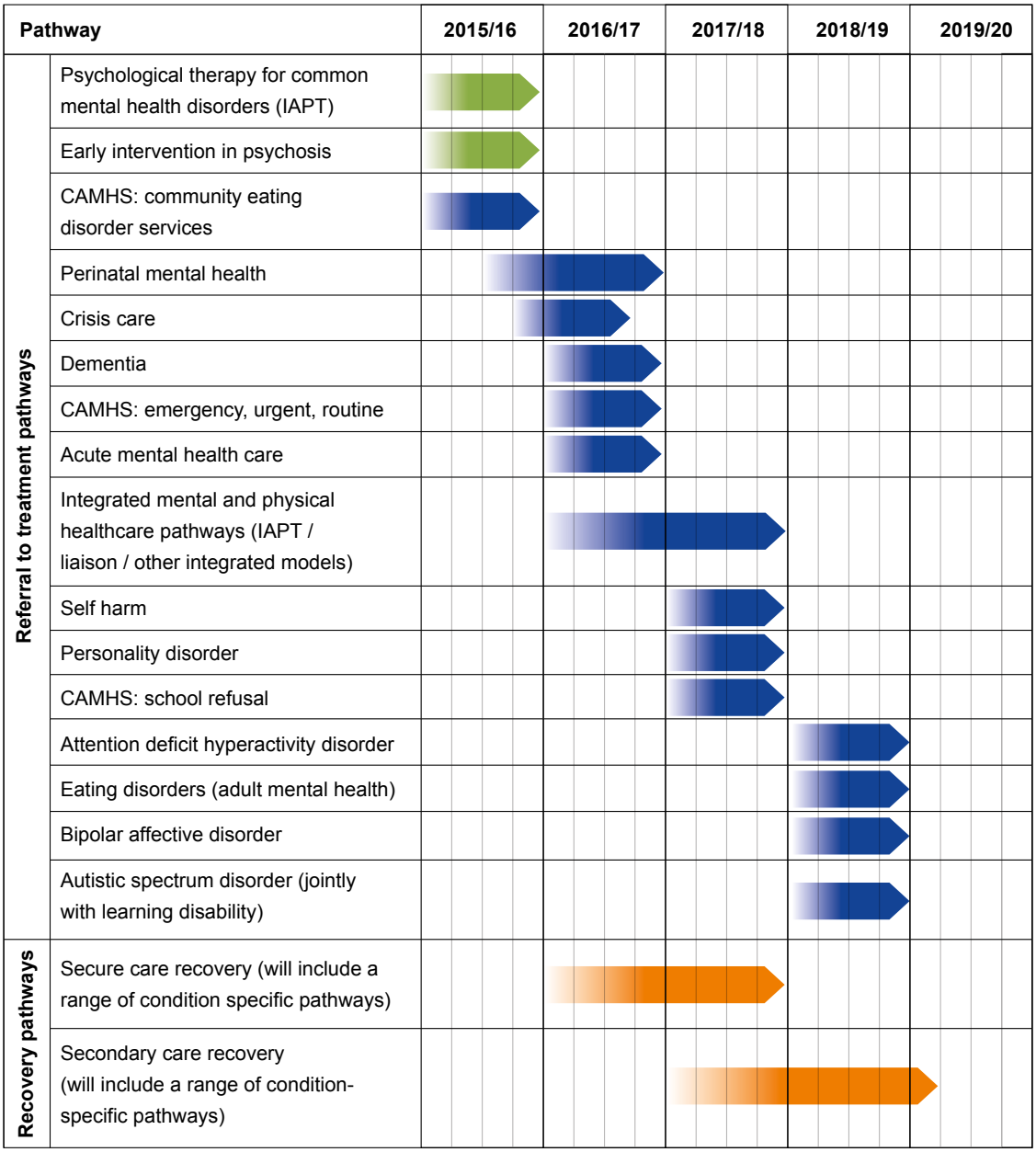
Recommendation 21: NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in the psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national Commissioning for Quality and Innovation (CQUIN) framework or alternative incentive payments, and embedded through the Vanguard programmes.

Recommendation 22: In 2016, NHS England and relevant partners should set out how they will ensure that standards are introduced for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible. These plans should include specific actions to substantially reduce Mental Health Act detentions and ensure that the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures is eliminated entirely by no later than 2020/21. Plans should also include specific action to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups within detention rates. Plans for introduction of standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17.

Recommendation 23: NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models.

Recommendation 24: The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.

Proposed mental health pathway and infrastructure development programme



There are a number of different mental health conditions, and the guidelines and quality standards produced by NICE are structured in line with broad diagnostic categories such as ‘psychosis’. The aim of the existing mental health access and waiting time standards programme is to ensure that a greater number of people have timely access to the full range of interventions recommended by NICE and receive the ‘right care, first time’. The proposed new standards have broadly been framed in line with NICE guidelines and quality standards, unless this makes little practical sense. For example, the crisis care standards will cut across multiple conditions because the focus must be responding rapidly to people’s needs in the most appropriate setting (although the aim will still be to ensure that people in crisis have access to care in line with NICE recommendations). The proposed programme also includes work to ensure that people who are already receiving support get care that is fully NICE-concordant, including psychological therapy, as a core part of co-produced care plans that are recovery and outcome-focused.

CHAPTER THREE:

INNOVATION AND RESEARCH TO DRIVE CHANGE NOW AND IN THE FUTURE

3.1 BUILDING ON INNOVATION

Every person with a mental health problem should be able to say:
I am confident that the services I may use have been designed in partnership with people who have relevant lived experience. I can access support services without waiting for a medical referral. I am able to access a personal budget for my support needs on an equal basis to people with physical health problems for example, to help my recovery or to stay well. My mental and physical health needs are met together.

I am provided with peer support contact with people with their own experience of mental health problems and of using mental health services. I can find peer support from people who understand my culture and identity. Peer support is available at any point in my fluctuating health – in a crisis, during recovery, and when I am managing being well. I have a place I can call a home, not just 'accommodation'. I have support to help me access benefits, housing and other services I might need.

There were also concerns from people from BAME communities, who told us they had lost trust in services and wanted more support within the community. More widely, we heard that community and voluntary sector providers play a critical role in supporting groups that are currently poorly served by services, such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs.

The Taskforce heard that there is a strong appetite for mental health research to be equitably funded and to have parity with other areas of health research. There was also support for much more research involving experts-by-experience, looking at what matters most to people in relation to prevention and care or support. Understanding the causes of mental ill health, including social and psychological factors, was considered a priority for research funding.

Delivering better care to more people not only requires increased investment. It also requires the development of new ways to improve the quality and productivity of services. We heard of many examples of approaches which had promise, but where further research was required.

This is already being applied: successful innovations, such as the Crisis Care Concordat, have led to the transformation of services, highlighting the importance of multi-agency partnerships and strong local leadership in implementing change. NHS Improvement should seek to stimulate other local initiatives building a broad pipeline of improvements from which others can learn.

Alongside new standards we need to see further innovation in three areas:

- **new models of care** to stimulate effective collaboration between commissioners and providers to develop integrated, accessible services for all - for example Integrated Personal Commissioning
- **expanding access to digital services** to enable more people to receive effective care and provide greater accessibility and choice - for example the digital initiative in London that will be operational later this year
- **a system-wide focus on quality improvement** to support staff and patients to improve care through effective use of data, with support from professional networks.

Innovation must be robustly evaluated as part of a strengthened approach to mental health research. NHS England should trial new approaches at scale, first in the 50 vanguard sites which are working to integrate health and social care, and second by creating an equivalent cohort of vanguard areas to pilot new approaches to delivering integrated specialist mental health care.

All new models must be developed in partnership with experts-by-experience, carers, and community and voluntary organisations. Psychological and social interventions, such as peer support and short-stay alternatives to hospital, are particularly valued by people with mental health problems and it is essential to demonstrate whether they also provide value for money.

We see a pivotal role for digital technology in driving major changes to mental health services over the next five years. There are already good examples of its use by NHS Choices, and there are a number of apps with a mental health theme. There is a large mental health community on social media and voluntary organisations report heavy demand on their digital services.

Provision must be increased so that:

- people can access services conveniently, have greater choice, and can network with peers to provide mutual support and guidance
- providers can deliver a more nuanced service, with contact through digital

media backed up by face-to-face interventions
- commissioners can improve outcomes through low-cost and easily scalable interventions
- providers can work securely to share patient data on electronic health records, where appropriate, to benchmark their performance and to test new service models
- people who use services, carers and the wider public can hold the system to account by using data across the entire pathway (from prevention and access through to productivity and outcomes) to scrutinise performance.

Our engagement activity brought home the critical role that people with experience of mental health problems, carers and staff can play in improving services. Yet we heard countless stories of promising ideas not being heard or taken forward. A whole-system approach is needed among the health ALBs to encourage constructive challenge.

Mental health problems account for a quarter of all ill health in the UK. Despite important new developments in mental health research it receives less than 5.5 per cent of all health research funding. Latest figures suggest that £115 million is spent on mental health research each year compared with £970 million on physical health research.

This disparity was highlighted by the Chief Medical Officer in her 2014 report. The biggest existing gaps include research into children's mental health, the promotion of good mental health and prevention of ill health, and the links between mental and physical health. One pound spent on mental health research realises an additional return of 37p each year, the same rate of return as for research on cancer and heart disease.

3.2 DELIVERING ON INNOVATION AND RESEARCH

We aim to create a simple pathway for innovation and research:
- identify areas of innovation and research promise
- invest in research programmes which include testing approaches at scale
- review research and embed it into care pathways and new models of care.

In future, new models of care will support people's mental health alongside their other needs, including physical health, employment, housing and social care and will have a greater emphasis on prevention, self-management, choice, peer support, and partnership with other sectors.

Specifically, new models of enhanced primary care and collaborative specialist care that meets the physical and mental health needs of people with severe mental illness will have been fully trialled.

People will also have greater choice and control over the services provided for them. They will be able to access good information, help and advice online, via live chat, email, text message and phone. Organisations will have the technology to collect data to improve their services. Mental health will be integrated into national and local transformation programmes and NHS commissioners supported to engage patients and staff in improving the quality and cost-effectiveness of care. There will be a more co-ordinated approach to research between government, private, public and philanthropic sectors over the long term and the involvement of people with lived experience of mental health problems as standard.

Mental health research should follow the roadmap set out in the ROAMER project, a collaboration of over 1,000 scientists, people using services, families, professional groups and industry representatives, published in September 2015, which identified the following priorities:

1. Preventing mental health problems arising, promoting mental health and focusing on young people
2. Focusing on the causal mechanisms of mental ill-health
3. Setting up international collaborations and networks for mental health research
4. Developing and implementing new and better interventions for mental health and wellbeing
5. Reducing stigma and empowering people with mental health problems and carers
6. Research into health and social systems.

3.3 NEW MODELS OF CARE

The new models of care being piloted by the vanguard sites offer opportunities to improve care for people with mental health problems by, for example:

- working with Primary and Acute Care Systems (PACS) to incorporate mental health screening and support within maternity pathways, and considering new payment models for integrating mental health care within tariff prices
- working with Multispeciality Community Providers (MCP) to provide integrated psychological support within wider primary care and community services provision, and supporting mental health inpatients more effectively to manage their physical health
- working with Urgent and Emergency Care (UEC) vanguards to ensure that sufficient liaison mental health and pathways to further care are available in acute hospitals to support those in mental health crisis.

NHS England should drive the development of new care models, starting with the implementation of NICE-recommended interventions. They should address current gaps in care and assess the work of relevant vanguards to benchmark how far mental health is reflected within their transformation plans to include:

- working with Jobcentre Plus, to expand access to IPS to help more people into employment
- trialling dedicated inpatient services for 16-25 year olds, as they transition to adulthood, following the model adopted for young cancer patients
- delivering extra training for primary care staff in supporting people with severe mental illness
- building a robust invest to save model for integrating psychological therapies into primary care through GP collaboratives
- developing new partnerships with the community and voluntary sector.

NHS England should support these innovations by working with current programmes to integrate commissioning across agencies, ensure commissioners and providers are confident to work in partnership with their communities, including people who use services and carers, and make more use of digital technology, as laid out in the National Information Board's strategy. A co-ordinated approach across ALBs, backed by experts in clinical improvement and good quality data, is essential to give local leaders effective support to implement necessary change.

Recommendation 25: The MCP, PACS, UEC Vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

Recommendation 26: The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now setting out a 10-year strategy for mental health research. This should include a coordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.

Recommendation 27: The Higher Education Funding Council for England (HEFCE) should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action

to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.

Recommendation 28: The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.

Recommendation 29: To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health and social work services.

Recommendation 30: NHS England and NHS Improvement should encourage providers to ensure that 'navigators' are available to people who need specialist care from diagnosis onwards to guide them through options for their care and ensure they receive appropriate support. They should work with HEE to develop and evaluate this model.

Recommendation 31: NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with vanguard sites.

CHAPTER FOUR:

STRENGTHENING THE WORKFORCE

Every person with a mental health problem should be able to say:
Services and professionals listen to me and do not make assumptions about me. Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective. The staff I meet are trained to understand mental health conditions and able to help me as a whole person. Staff support me to be involved in decisions at the right level. They respond flexibly and change the way they work as my needs change. Wherever possible, there are people with their own experience of using services who are employed or otherwise used in the services that support me. As far as possible, I see the same staff members during a crisis.

My culture and identity are understood and respected when I am in contact with services and professionals. I am not stigmatised by services and professionals as a result of my health symptoms or my cultural or ethnic background. The strengths of my culture and identity are recognised as part of my recovery. My behaviour is seen in the light of communication and expression, not just as a clinical problem.

The Taskforce heard a strong message that staff across the NHS need to have training that equips them to understand mental health problems and to treat people with mental health problems with dignity and respect: treating 'the person, not the diagnosis'. This is critical in enabling people with mental health problems to play a more active role in making choices about all aspects of their care, based on a more equal and collaborative relationship between the person and professional(s). A number of people described encountering stigmatising attitudes from some staff within mental health services, as well as staff in the wider NHS (including GP surgeries and non-clinical staff). Developing a paid peer support workforce had considerable support. People also wanted clearer protocols for staff when they are working with carers.

Professionals and professional bodies wanted the NHS as an employer to pay greater regard to the health and wellbeing of NHS and social care staff, as an effective way to improve the quality of care at a time when staff are under increasing pressure.

4.1 THE PICTURE TODAY - STAFF WORKING HARD IN A TOUGH ENVIRONMENT

Building and maintaining a qualified workforce of committed staff is one of the greatest challenges facing the NHS - and it is most acute in mental health. Providing specialist care to people experiencing mental distress is difficult, demanding work and requires exceptionally dedicated, caring individuals. It calls for multi-disciplinary teams, including psychiatrists, mental health nurses, psychologists, occupational therapists and social workers. There are significant opportunities for increasing access to high quality, integrated care that rely upon an expanded workforce with the right skills, but recruitment is not easy in some areas.

Data from 2014 from Health Education England (HEE) indicate a 6.3 per cent vacancy rate for NHS consultant psychiatrist posts, and over 18 per cent of core training posts in psychiatry are currently vacant. Psychiatry has the slowest rate of growth and the highest drop-out rate of any clinical specialty.

Between 2013/14 and 2014/15, referral rates increased five times faster than the Child and Adolescent Mental Health Services (CAMHS) workforce. Some areas report one in ten appointments cancelled because of staff shortages, specialist CAMHS run by junior staff who lack the requisite skills and too few therapists with the necessary training.

According to the King's Fund report 'Under Pressure' almost half of community mental health teams surveyed had staffing levels judged to be less than adequate in 2013/14 and many more were unable to provide a full multi-disciplinary team. Demand for temporary mental health nursing staff has risen by two thirds since the beginning of 2013/14. Staff shortages have contributed to deaths on inpatient wards, according to the 2015 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, and they have also been blamed for the rise in detentions.

Mind reported that in 2011/12, there were almost 1,000 incidents of physical injury following restraint in mental health services, with considerable variation between trusts. According to NHS Benchmarking, use of restraint has increased this year.

Workforce planning for mental health across the entire care pathway has not been developed and as a result opportunities are being missed to identify how changes in skill mix could help improve delivery, retain staff and tackle the highest vacancy rates.

A chink of light has appeared in the past year: there have been small increases in staffing on adult and older people's inpatient wards, driven by the safer

staffing initiative and new initiatives to increase social workers in mental health. However, bed occupancy rates have also risen.

In 2015, a five year plan began, led by NHS England and HEE, to set staffing levels to deliver high quality care under the existing standards programme. For example, to meet the access standard for Early Intervention in Psychosis, this has identified what staffing needs are required including psychologists, therapists, care co-ordinators, vocational workers and psychiatrists. Further work is needed by NHS England and HEE to expand this programme to put into action the full range of pathways and standards described in Chapter Two.

Staffing is not just a question of numbers. The resilience and wellbeing of staff is also critical. Morale varies widely across the system today, linked with pressure of work and level of training, according to the Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists. Yet the Royal College of Physicians found fewer than half of NHS trusts had a plan in place to promote staff wellbeing.

It goes without saying that people seeking NHS care need to be treated with compassion. But what is sometimes forgotten is that staff do too. The care they receive impacts on the care they are able to deliver. Ten million working days are lost each year to sickness absence in the NHS. Some 43 per cent of mental health staff cite work related stress as the cause, second only to ambulance trusts at 51 per cent. Findings from the British Psychological Society and New Savoy staff wellbeing survey for 2015 show that around half of psychological professionals surveyed report depression. Seventy per cent say they are finding their job stressful. Yet the quality of the NHS occupational health service is inconsistent and, in some cases, inadequate, according to the NHS Health and Wellbeing Review.

Despite the pressures, we heard many positive and inspiring stories about the quality of care provided by NHS staff for people with mental health problems. We also heard that some have poor attitudes to mental health. The CQC report ‘Right here, Right now’ found less than four in ten people (out of 316 surveyed) accessing A&E felt listened to, taken seriously and treated with warmth and compassion. Among those in touch with specialist mental health crisis services the response was only slightly more positive with half (of 748 surveyed) saying they were well treated. GPs, ambulance staff and the police were perceived as more caring and voluntary organisations as being the most caring of all.

Race discrimination is still perceived by some as a problem according to the CQC. The introduction of the NHS Workforce Race Equality Standard is welcome and must be monitored closely.

Primary care staff are not yet fully equipped to provide high quality mental health care. More than four out of five practice nurses have responsibilities for which they have not been trained, with 42 per cent having no training at all in mental health, according to the Royal College of GPs. The training of GPs could also be improved to ensure they are fully supported to lead the delivery of multi-disciplinary mental health support in primary care.

Drugs for mental health problems can have serious side effects, such as causing rapid weight gain, but standards in the prescribing of anti-psychotics and other medications are not consistently adhered to, according to the Prescribing Observatory for Mental Health.

Shared decision-making between the person being supported and their practitioner is known to improve the quality of care by increasing active involvement, self-management and confidence. Yet less than half (42 per cent) of people using community mental health services “definitely” have a care plan and only just over half (56 per cent) said they were “definitely” involved as much as they wanted to be. New models are appearing. In secure care services, an approach to collaborative planning has been developed called My Shared Pathway which should be robustly evaluated.

Carers have a unique role to play for some people with mental health problems, and are often responsible for navigating complex health and social care systems and providing support to help the person manage. This includes the children of parents with mental health problems, who are likely to provide a caring role. Mental health practitioners should have the knowledge and skill to involve carers appropriately, including working with the person using the service and carers to determine what information can be shared between the three parties.

Peer support is highly valued, especially by young people and BAME adults, and should be developed as a core part of the multi-disciplinary team.

4.2 THE WORKFORCE IN THE FUTURE - MENTAL HEALTH AS THE PROFESSION OF CHOICE

As public interest and awareness of mental health increases and stigma diminishes, many more people are considering a career in mental health. The Think Ahead programme, a “Teach First” approach for social workers in mental health, has had in excess of 2,000 applicants for its first 100 places. There is the potential to put in place an approach that encourages more young people to choose a career in mental health, and more peer support.

The right workforce with the right skills is the single most important component of good care. All frontline staff, including those in the criminal justice system, should have basic skills to provide mental health care. Urgent work to jointly develop robust health and social care workforce planning for mental health must start now to:

- identify and fill workforce gaps
- provide the right training and support
- involve carers, as appropriate
- provide annual projections for staff numbers and costs.

The 'Public mental health leadership and workforce development framework' has been published by Public Health England. It should be implemented in full. Staff should be trained to prevent ill health, working across traditional boundaries, in line with its recommendations. The need for access to effective social work as part of good quality mental health care should also be recognised through the routine inclusion of social workers in NHS commissioner and provider workforce planning.

Mental health staff should be trained to treat people with sensitivity, in the least restrictive way possible, prescribing in line with standards and using restraint only in exceptional circumstances. There should be a greater focus on mental health awareness for all front-line staff. This will involve cultural change and require strong leadership.

Staff should work in partnership with the people using services to develop plans based on the personal goals of the individual. Peer support should be offered from people who have had similar experiences and carers should be given help to play an appropriate role. Restraint will be used only as a last resort.

By 2020/21, measures to improve staff morale and wellbeing will be in place, backed by good data, and people with mental health problems will experience an improvement in staff attitudes. Training will have been strengthened and new models of care expanded. Most care should be provided in community and primary care settings.

Protecting the mental health of the workforce is also vital. NHS England has committed to helping staff make choices to improve their own health, and mental health is a key part of that. This should apply across the NHS – building on positive initiatives within ambulance trusts. Every NHS trust should become an 'enabling' environment, as recommended in the Francis Report, so people want to work there. Trusts should monitor the mental health of their staff and provide effective occupational health services.

Recommendation 32: HEE should work with NHS England, PHE, the Local Government Association and local authorities, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This must report by no later than 2016.

Recommendation 33: NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.

Recommendation 34: NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.

Recommendation 35: NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.

Recommendation 36: The Department of Health and NHS England should work with the Royal College of GPs and HEE to ensure that by 2020 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.

Recommendation 37: The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding ‘Think Ahead’ to provide at least an additional 300 places.

Recommendation 38: By April 2017, HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, and take into account people’s personal preferences, including preventative physical health support and the provision of accessible information to support informed decision-making.

CHAPTER FIVE:

A TRANSPARENCY AND DATA REVOLUTION

The Taskforce heard from a range of stakeholder organisations that data and transparency are critical aspects of a system that delivers good outcomes. Work needs to happen to link data from different public services and agencies (the NHS, social care, education, criminal justice and others) to help identify and meet the full needs of people with mental health problems. Similarly, there should be more national support with the analysis and presentation of raw data to support good commissioning and local planning.

Organisations representing different communities emphasised the importance of equalities monitoring by providers for greater transparency about access, quality and outcomes for various groups. This should help ensure that the provisions of the Human Rights Act and the Equalities Act 2010 are being met. Several organisations also stated that there needs to be greater transparency in how resources are allocated to mental health across NHS settings, the quality of services provided and to what extent they are improving outcomes.

5.1 A "BLACK HOLE" OF DATA

Understanding how quickly people are able to access services, what sort of care they are receiving and what outcomes they are experiencing is vital to good care. Consistent and reliable data in mental health, however still lags behind other areas of health. There is good information available, but it is not co-ordinated or analysed usefully.

National data are collected through the Mental Health Services Data Set (MHSDS) by the Health and Social Care Information Centre (HSCIC) on behalf of the Department of Health. The MHSDS began operating on 1 February 2016 and its reporting capability is yet to be tested.

Prior to that point data reporting has been sporadic and the HSCIC has warned it will not be able to meet reporting needs quickly now the MHSDS is operational. Changes to the dataset can take more than 12 months which will limit the immediate usefulness of the MHSDS. For adults, data is also grouped together under 'clusters' which can inform how services are paid for but do not align with diagnosis or NICE guidelines so it not clear whether people are getting recommended interventions. The 'cluster' currency provides an indication of individual need and has demonstrated the ability of services to report high quality data (the cluster currency has been mandatory for providers since 2012). However, this approach still does not provide the right kinds of incentives i.e. across pathways of care or to promote good outcomes. It may even encourage perverse incentives, such as paying more where people move into crisis or become acutely unwell.

Some datasets are better quality than others – for example the national data on access to psychological therapies for common mental health problems are robust. Collection of data on children and young people has been subject to delays and the data itself lacks clarity. We also do not have ready access to local and national equalities data, showing us breakdowns in access and outcomes across groups protected by the Equality Act 2010.

The National Mental Health Intelligence Network (NMHIN), run by PHE, with support from NHS England and the Department of Health, presents data to help improve commissioning and service provision. In some areas, it is well developed, providing details on levels of access, spending and social care. But it lacks the analytical capacity of other health data networks. PHE publishes additional resources for children and young people on the Chimat website although it also lacks analytic power.

Financial reporting is an important indicator for scrutinising commissioning and provision. Yet it is not consistently available in mental health. Provider level data is also linked to care 'clusters' and reference costs for the clusters vary hugely across the country, partly due to lack of consistency in their use and partly to variations in the services provided. Clusters describe the needs that people present with but do not clearly align with the care that NICE recommends, making it difficult to establish the true funding picture. While CCG programme budgets for physical health are broken down by disease, there is only one category for mental health. Local information on investment in care, by condition, is therefore essential.

An important barrier to good care is the lack of appropriate data sharing to enable organisations to identify co-morbidities, anticipate problems and plan care in a holistic fashion. People with poor mental health may require primary care, secondary physical care and social care, as well as mental health services, but the lack of linked datasets hinders effective provision.

The Summary Care Record (SCR) is an attempt to address this by including key primary care information about an individual such as medication, allergies and adverse reactions. But it does not routinely include care plan information or allow access to mental health care records (or physical care records) which is a significant missed opportunity.

Good data are also necessary to allow people to make an informed choice of service. However, the information on mental health on 'myNHS' is limited to CQC ratings and clinical audits. Waiting times for care and the range of interventions on offer would be more relevant to choosing a provider.

5.2 A TRANSPARENCY REVOLUTION

The inadequacy of good national mental health data and the failure to address this issue until recently has meant that decisions are taken and resources allocated without good information, perpetuating a lack of parity between physical and mental health care.

This lack of transparency has also had a negative impact on confidence in mental health services - we heard that many people felt that additional resources didn't reach the front line. Data about outcomes and acceptable levels of variation are unclear, but we are encouraged by the work of the NHS Benchmarking Network.

In the future, the quality of mental health services and how well they are meeting the needs of the local population will be demonstrated through the provision of accurate, relevant, timely data which will be collected routinely for each person with mental health problems receiving care.

National datasets will include information on diagnosis, interventions and outcomes and be appropriately linked with other datasets, such as for physical health and social care. The Department of Health, NHS England and PHE will lead the transformation in mental health information, with changes to HSCIC data collection backed by new funding.

The NMHIN and Chimat will provide comprehensive data resources to inform good quality commissioning and allow services to be benchmarked against each other, highlighting best practice and ensuring resources can be targeted where they have most impact. Commissioners will be able to assess prevalence, predict incidence and plan provision and identify individuals repeatedly admitted to inpatient care in order to target them for preventive interventions.

Budget reporting will be aligned to specific mental health conditions, increasing transparency. Everyone will be able to assess the responsiveness of services to local population needs, including the needs of marginalised groups covered by equalities legislation.

People using mental health services will be able to make informed choices about their care and how their data is used. Care will be increasingly personalised and measures will capture how well it is helping them achieve their goals. Individuals will be able to rate services, holding commissioners and providers to account.

5.3 PUTTING IN PLACE DATA PLANS

Providing high quality mental health care requires the collection of the right kind of mental health data, at the right time. The National Information Board has been charged with delivering this ambition. Their task now should be a national stock take of mental health data to ensure it includes the most meaningful measures, which align with national priorities, and that collecting it does not place undue pressures on clinicians and service managers. Clinical system suppliers, mental health commissioners, providers and experts-by-experience should be involved.

The transition to the MHSDS provides an opportunity to reconsider which data should be collected and reported. The HSCIC should develop a package of support to solve problems related to getting, using or sharing data.

More work is needed to ensure data can be linked across public agencies, to promote integration of care and generate insight into where people are accessing different parts of the system and, ultimately, what their needs, preferences and outcomes are.

PHE should work with other national agencies to develop the NMHIN as the trusted national repository of robust and publicly available mental health data and intelligence over the next 5 years.

A review of national clinical audits and how they supplement mandated datasets should be carried out, including the Prescribing Observatory for Mental Health UK, the National Audit of Schizophrenia and NHS Benchmarking club data. ‘Future in Mind’ also identified significant gaps in data on children and young people’s mental health and these must be addressed.

Recommendation 39: The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services. They should also publish a summary progress report by the end of 2016 setting out how the specific

actions on data, information sharing and digital capability identified in this report and the National Information Board's Strategy are being implemented.

Recommendation 40: The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017.

Recommendation 41: The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health Five Year Forward View Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include employment and settled housing outcomes for people with mental health problems.

Recommendation 42: NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary.

Recommendation 43: During 2016 NHS England and PHE should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.

Recommendation 44: By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing datasets by no later than summer 2016.

Recommendation 45: The Department of Health and HSCIC should advocate the adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.

Recommendation 46: The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every seven years.

CHAPTER SIX:

INCENTIVES, LEVERS AND PAYMENT

The Taskforce heard from a number of stakeholder organisations that the way services are contracted and paid for affects the quality of care people receive across settings. This includes a lack of transparency and accountability associated with the use of 'block contracts' which do not specify how many people will be supported by the service or the quality of care they should receive. The Taskforce also heard that the way services are currently paid for can prevent them from being integrated e.g. acute physical health services are not paid to include mental health support, even though this is good practice. Organisations said that the development of more effective payment models is heavily dependent on robust data about the quality of services.

6.1 THE CURRENT APPROACH TO AN UNEVEN PLAYING FIELD

Mental health services have been plagued by years of under investment. More than half of mental health trusts are paid using block contracts providing a fixed amount unrelated to how local needs are being met or the quality of care provided. This rewards those that deliver low cost interventions, regardless of outcome, and penalises those that increase access or deliver more costly interventions, even though they may improve outcomes. This payment method also affects the development of personalisation in mental health care, since without more detailed information about individuals receiving care, the costs of that care, or clear care pathways, it is difficult for funding to be released through Personal Health Budgets or integrated with social care funding to support Integrated Personal Commissioning (combined personal budgets).

Some areas are moving away from block contracts but mental health is being left behind and thus lacks the financial levers to drive change. National guidelines to reward quality and outcomes are being poorly implemented at local level. There is also a risk that new models of care will make greater use of block contracts, which is not currently appropriate for payment of mental health interventions where there is little transparency around quality and outcomes.

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

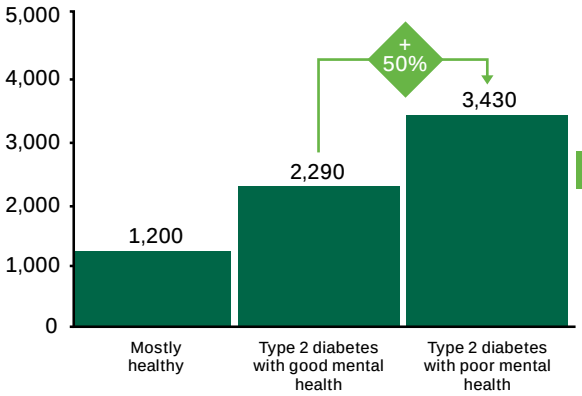
Two new payment models are proposed for adult care in 2016/17 (for 2017/18). One is based on the year of care or episode of care appropriate to each of the mental health care clusters. The second is a capitation-based payment tied to care clusters or similar data. Both link payment in part to quality and outcome measures. NHS Improvement and NHS England are asking commissioners and providers to adopt one of the two approaches.

Several of the vanguard sites are adopting the capitation model but are using historic spending to set annual budgets. This risks reinforcing previous underinvestment. Some CCGs are developing local outcomes-based contracts. This is also encouraging but without a national approach, opportunities to share evidence about which models deliver the best outcomes may be lost.

Presence of poor mental health drives a further 50% increase in costs

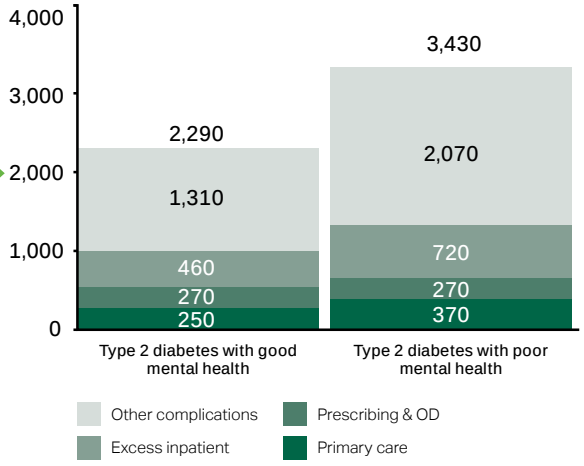
Physical healthcare costs 50% higher for type 2 diabetics with poor mental health

Annual physical healthcare costs per patient, 2014/15 (£)



Additional costs due to increased hospital admissions and complications

Annual physical healthcare costs per patient, 2014/15 (£)



Presence of poor mental health responsible for £1.8bn of spend on type 2 diabetes pathway

Note: Does not include spend on prescribing psychiatric drugs and other mental health services
Source: Hex et all, 2012; APHO Diabetes Prevalence Model for England 2012; Long-term conditions and mental health: The cost of co-morbidities, The King's Fund

Better integration with physical health is vital but payment models do not incentivise this. For example, payments for diabetes and cancer care do not routinely cover psychological interventions and payments for mental health care do not ensure physical health needs are met as standard.

There is one national CQUIN that rewards mental health providers for ensuring that the physical health needs of people with psychosis are met. This supports working relationships between specialist mental health providers and primary care which can avoid relapses and crises. Introduction of the CQUIN has seen physical care monitoring rise by a third, but performance is still well below target.

6.2 A FUTURE APPROACH TO A LEVEL PLAYING FIELD

In future, payments should incentivise swift access, high quality care and good outcomes, while deterring cherry picking of people who seem 'easiest-to-treat'. Payment models should include a range of capitated or population-based approaches. Wider levers include the NHS standard contract, CQUINs, quality premiums, sanctions and regulation, which should be used to encourage good performance. A full set of principles underpinning what the new approach to payment in mental health should look like is annexed.

Payments should incentivise provision of integrated mental and physical healthcare and be adjusted to account for inequalities. Funding decisions should be transparent and public, including those of the independent Advisory Committee for Resource Allocation (ACRA) for the NHS.

NHS England and NHS Improvement will need to provide robust support to providers and commissioners to introduce new payment approaches for adult mental health based on either capitated or episodic/year-of-care payment models and which reward improved outcomes, quality and access. Where progress is not being made, regulation, assurance and enforcement may be necessary. Similar changes are needed for children and young peoples' services and psychological therapy services, and to incentivise the provision of mental health care to people with physical health problems.

Physical health providers will need to be reimbursed for meeting mental health needs which may require re-classification of patient care described by Healthcare Resource Groups (HRGs), Treatment Function Codes (TFCs) and Office of Population Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS) codes.

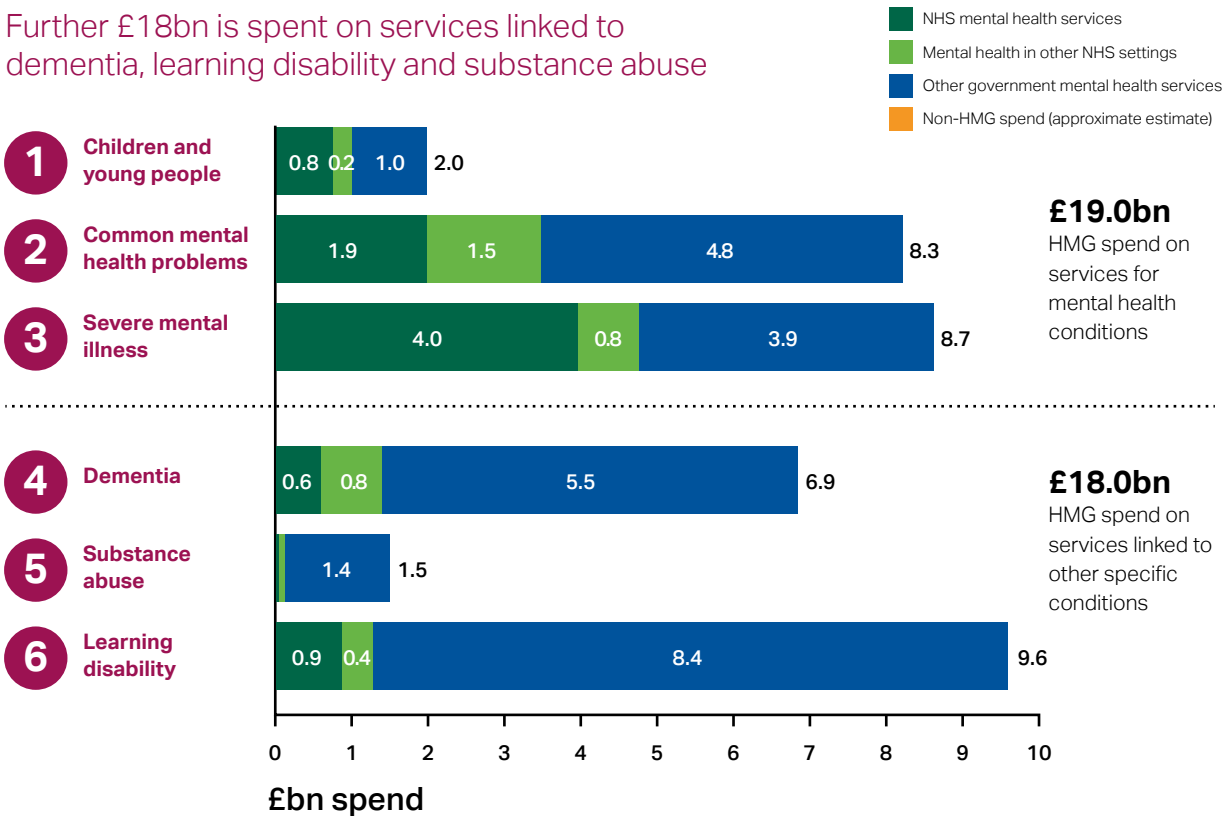
A new CQUIN to improve the recognition and treatment of depression in older people should be introduced, modelled on the dementia CQUIN. Since its introduction, the dementia CQUIN has raised the profile of the disease in

general acute hospitals, and is now finding 90 per cent of people with possible dementia.

NHS funding formulae must be reviewed by ACRA to ensure they support parity between mental and physical health. They should also be reviewed to ensure it correctly estimate the prevalence and incidence of conditions across the mental health spectrum.

In respect of the annual inequalities adjustment given to CCGs for people with the poorest access and outcomes in health, CCGs should also report how their spending is related to need, access and outcomes for mental health. Mental health funding should be allocated to individual conditions in the same way as physical health funding to make it easier to track. Good quality data will be needed to determine whether care is cost-effective and whether new approaches are more appropriate than existing ones.

£19bn is spent on services for mental health conditions



Note: Dementia healthcare expenditure only includes spend on mental health services for dementia, not on physical health co-morbidities (e.g. diabetes), which would increase spend by £3bn

Recommendation 47: NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people's services as soon as possible.

Recommendation 48: NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and primary care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and inequalities in access and outcomes.

Recommendation 49: ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

Recommendation 50: The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for children and Adolescent Mental Health Services, from 2017/8 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase.

CHAPTER SEVEN:

FAIR REGULATION AND INSPECTION

Every person with a mental health problem should be able to say:
I feel safe. My strengths, skills and talents are recognised and valued. I am treated as a person, not just according to my behaviour. My personal goals are recognised by support services. I choose who to consider the people 'close to me', who can support me in achieving mental wellbeing. I am able to see or talk to friends, family, carers or other people who I say are 'close to me' at any time. I can determine different levels of information sharing about me. I am confident that if I need care or treatment, timely arrangements are made to look after any people or animals that depend on me. I feel confident that my human rights are respected, protected and progressively realised in all systems of regulation and inspection.

If I raise complaints or concerns about a service these are taken seriously and acted upon, and I am told what has happened in response. If I do not have capacity to make decisions about my care and treatment, any advance statements or decisions I have made will be respected. I am supported to develop a plan for how I wish to be treated if I experience a crisis in future. As far as possible, people who see me in a crisis follow my wishes and any plan I have previously agreed. When I need medicines, their potential effects – including how they may react with each other – are assessed and explained.

7.1 THE SYSTEM TODAY: HIGH LEVELS OF SCRUTINY PAINTING A MIXED PICTURE OF EXPERIENCE

Many stakeholders believe that the legislative and regulation framework underpinning mental health care can be improved.

The Mental Health Act 1983 provides a legal framework for the detention of individuals with mental health problems in order to be assessed and treated (including with medication) for mental illness without regard to their mental capacity or their ability to give or withhold consent. This applies if they have

a mental illness which requires assessment or care in a hospital and they are detained because they are assessed as posing a risk to themselves or others.

The Mental Capacity Act 2005 makes no distinction between the mental and physical with regard to decisions about care. But the 2005 Act's provisions about having the mental capacity to consent to care can be over-ridden in the case of mental health care by the 1983 Act. We heard that this can act as a barrier to making parity of esteem a reality because it enshrines differences in the treatment of people with mental and physical health problems and frames care as a method of social control rather than a therapeutic intervention. The 1983 Act should therefore be reviewed as part of the continuing drive for greater parity with physical healthcare.

Commissioners, providers and the CQC should ensure that the full range of people's human rights are protected at a time when their capacity, autonomy, choice and control may be compromised. This is reinforced by the Care Act 2014. However, the number of people detained and the number subject to restrictive Community Treatment Orders (CTOs) requiring them to adhere to particular interventions, including medication, continue to increase. The use of CTOs is much higher than anticipated when they were introduced in 2008, yet findings from a recent Oxford University study show they are not effective for the majority of people.

The Health and Social Care Act 2012, as reflected in the NHS Constitution, provides rights to specialist care, including access to consultant-led treatment within 18 weeks of referral and a choice of provider. However, there is not yet parity between an individual's rights to physical and mental health care. Although the right to choice of provider has been extended to mental health there is no legal right to recommended interventions or maximum waiting times, as there is for physical health care.

The CQC has a robust approach to regulating the quality of NHS service provision. However, inspection of mental health support in primary and acute physical health care settings should be strengthened. We must also ensure psychological therapies are properly regulated.

The only detailed measure of people's experience of mental health care is through the CQC survey of community mental health services. But this is inadequate, as revealed by the CQC's special inquiry into crisis care which showed that people's experiences of mental health care across other settings were very mixed and should be tracked on a regular basis. There is also no measurement of people's experience of inpatient mental health care, including secure care, despite the nature of compulsory treatment and the potential vulnerability of those who are detained, in some cases for months or years.

The Taskforce heard that the experience for people who are marginalised needs to be improved, with particularly strong messages coming through from BAME groups. The Workforce Race Equality Standard is a welcome development in the NHS for those providing services. But there is no equivalent for those accessing them. The 5-year Delivering Race Equality programme concluded in 2010 that there had been no improvement in the experience of people from minority ethnic communities receiving mental health care. Data since shows little change. These inequalities must be prioritised for action, and we support the recommendations of The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists on this issue.

There were 198 deaths of people detained under the Mental Health Act in 2013/14, the majority of which were due to natural causes, including preventable physical ill health. Care providers must ensure that they take appropriate steps to prevent the avoidable deaths of people in inpatient care, including people of all ages who are deprived of liberty through detention under the Mental Health Act. However, unlike in prison or police detention, where every death is independently investigated, there is no independent pre-inquest process in place for investigating these deaths. Care organisations themselves carry out internal investigations. As highlighted by the recent findings within Southern Health NHS Foundation Trust, the quality of internal investigations can be poor and providers are not always able to demonstrate robustly how they have learned from them and made improvements.

There are no published death rates in individual units or by CCG area, no information on whether death has occurred in a public or privately run organisation, and no information on the number or nature of deaths that have occurred in specific settings. Patterns of deaths that merit closer examination may thus escape public scrutiny. In particular, there are questions about the over-representation of black people in mental health settings and the use of force that features in some of their deaths. There is also very limited information available nationally on the number of children who have died in mental health settings.

Measurement of wider social outcomes – such as finding a job and accommodation – is also a marker of the quality of services and varies across organisations. Yet these outcomes can be more meaningful than strictly clinical outcomes such as being “symptom free”.

THE SYSTEM IN THE FUTURE

The full range of regulatory levers will be used to address inequalities and improve the quality and experience of people receiving mental health care. The right to equal treatment in the least restrictive setting will be clearly enshrined

in legislation, and all providers will ensure they work in accordance with Human Rights legislation.

Strengthened inspection of mental health care by the CQC will be extended to all NHS-funded providers, including primary and acute physical health care. Measures of quality will show how services compare and specialist mental health services, including inpatient care, will include self-reported outcomes. Racial and other inequalities in rates of detention will be addressed and there will be greater transparency in the causes of deaths and how they can be prevented.

SYSTEM REFORMS BY 2020/21

It is essential that people's human rights to receive care in the least restrictive setting, to give or withhold consent, to use advance decisions and to maintain family life are respected and that inspections assess the extent to which these rights are supported. Individuals deprived of their liberty under the Mental Health Act should be offered information, advocacy and support. In the light of rising rates of detention and the high and potentially inappropriate use of CTOs, highlighted by research published by Oxford University in 2013, there is a strong case for considering whether the current legislative framework strikes the right balance between risk and consent. This should include consideration of how mental capacity legislation should be applied in the use of the Mental Health Act to detain a person for compulsory treatment. This is a fundamental aspect of ensuring parity between mental and physical health.

The whole NHS plays a role in preventing mental health problems and caring for people who suffer them. The inspection system should be updated to ensure it covers all aspects of mental health provision in all settings, and all physical and mental health pathways of care.

For children and young people, we support the recommendation in 'Future in Mind' that the CQC should work with Ofsted to develop a joint, cross-inspectorate view of how health, education and social care services are working together to improve their mental health.

In July 2015, the Secretary of State for Health announced the creation of a new Healthcare Safety Investigation Branch (HSIB). The Branch will be established from April 2016 and will provide support and guidance to NHS organisations on investigations, as well as carrying out certain investigations itself. It will also conduct national investigations into safety incidents and act as an exemplar. It will focus on incidents that signal systemic or apparently intractable risks within the local health care system. The Department of Health should ensure that the scope of the HSIB includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, local and national trends, and evidence that learning is resulting in service improvement.

Recommendation 51: The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of a individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.

Recommendation 52: The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated, to access to care within maximum waiting times).

Recommendation 53: Within its strategy for 2016–2020, the CQC should set out how it will strengthen its approach to regulating and inspecting NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups.

Recommendation 54: The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless they are provided within secondary mental health services.

Recommendation 55: The CQC should work with Ofsted, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people's mental health outcomes.

Recommendation 56: The Department of Health should ensure that the scope of the Healthcare Safety Investigation Branch includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement.

Recommendation 57: NHS Improvement and NHS England, with support from PHE, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements, are learned from, to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.

CHAPTER EIGHT:

LEADERSHIP INSIDE THE NHS, ACROSS GOVERNMENT AND IN WIDER SOCIETY

We have recommended an ambitious but deliverable strategy for mental health to realise improvements in prevention, access, outcomes and experience, backed by a strong clinical and economic case for investment. Implementing it will require robust leadership.

We commissioned a review by the Centre for Mental Health which identified 12 key elements necessary for the successful implementation of our vision:

1. **Leadership**: Effective national and local leadership is vital.
2. **Focus**: Strategies with a clear narrative and a set of widely supported, prioritised action points are more likely to succeed.
3. **Funding**: Funding for change and the associated double running costs is particularly important.
4. **Incentives**: Effective mental health strategies have benefited from close alignment with the incentives used in mainstream health policy.
5. **Workforce**: The most important changes are often the least amenable to policy-making and depend on the motivation of staff.
6. **Scrutiny**: Visible accountability for achieving a strategy's goals is essential to sustain implementation.
7. **Public opinion**: Strategies that enjoy support from the public and professionals are more likely to be implemented well.
8. **Partnerships**: Mental health policy relies on organisations working together.
9. Implementation: Robust, stable and supportive implementation infrastructure is vital.
10. **Innovation**: Policy cannot stand still but needs to facilitate innovation.
11. **Management**: Good quality programme and project management is essential.
12. **Time**: Changing practice takes longer than policymakers think. Policies need time to be implemented effectively.

Building on this evidence, a robust governance framework should be put in place to implement a 5-year programme to transform mental health care in

England. This strategy should be refreshed in 2019/20 in the light of new data that will emerge.

The key elements should be:

- **Establishing NHS England as the lead ALB** with responsibility for overall delivery of the strategy, led by the appointment of a new Senior Responsible Officer.
- **Embedding co-production** within the design and delivery of the programme, through the involvement of those with experience of mental health services and the organisations that represent them. This should include creating an independent external advisory board to provide independent scrutiny and challenge to the programme.
- **Establishing a new cross-ALB programme board** as a single coherent governance structure for delivering the strategy at a senior operational level, including defining the best approaches for local delivery.
- **Appointing an equalities champion,** with a specific remit to tackle mental health inequalities across the health system and through cross-government action.
- **Ensuring the necessary level of resource** within the national team overseeing day-to-day implementation.

The Department of Health, Cabinet Office and NHS England should put in place clear mechanisms for ensuring that the cross-government recommendations made in this report are implemented in full, and support continued action to combat stigma and discrimination in our society.

The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health. This should be given full consideration as quickly as possible as part of the remit of the new equalities champion.

Without additional investment it will not be possible to implement this strategy and deliver much-needed improvements to people's lives, as well as savings to the public purse. Funding is required in priority areas to help put the essential building blocks in place to improve the system over the long-term and to increase access to proven interventions that improve outcomes and deliver a return. We have identified that a minimum of £1 billion should be available in 2020/21. There should be a clear message that there is an expectation that more people are able to access NICE-evidenced services and that levels of investment in mental health should reflect this, across primary care, acute and mental health systems. Expenditure on mental health should be fully transparent.

Our proposals for investment are primarily targeted at expanding access to evidence-based care and scaling up effective programmes of work, supported by system reforms that are already happening and where the NHS can expand workforce capacity relatively quickly.

However, the Taskforce recognises the reality that reinvesting in services, planning for and recruiting into workforces that in many cases have been depleted in recent years, and initiating the essential system reforms required to support service expansion and transformation (e.g. relating to data and financial incentives) takes time.

Our proposals therefore focus on consolidating and expanding programmes for children and young people, for perinatal care and for Early Intervention in Psychosis 2016/17, in parallel to laying the ground for wider investment across the full range of priorities for action from 2017/18 onwards.

Securing new investment and realising the associated savings will require commissioners and providers, nationally and locally, to demonstrate that they are delivering high quality care and value for money within their budgets. This means implementing evidence-based standards, supporting quality improvement, improving data on outcomes and spend, a strong commitment to transparency, and integrating services at every level to meet the needs of their population. The transformation programme for Improving Access to Psychological Therapies for Children and Young People is a good example of how this can work. To make best use of new investment and ensure savings will materialise on the ground NHS England must also begin work now with ALB partners and local areas to trial new models of implementation.

We know that the scale of unmet mental health need is significant – hundreds of thousands of people go untreated each year at a cost of billions of pounds to our society and the economy. This investment would, however, make a start in plugging that gap, building on £1.4 billion of new funding over five years for children and young people's and perinatal mental health last year, including additional funding for eating disorders.

Mental health must remain a priority in a challenging financial climate for the NHS in the next five years, which is why we have set out specific recommendations to ensure that there is proper transparency and accountability for how money is spent. At a minimum, from 2016/17 we expect CCGs to be able to demonstrate how they will increase investment in mental health services in line with their overall increase in allocation each year or in line with the growth in recurrent programme expenditure.

Recommendation 58: By no later than Summer 2016, NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners, and the appointment of a new equalities champion for mental health to drive change.

ANNEX A:

PRINCIPLES UNDERPINNING PAYMENT APPROACHES IN MENTAL HEALTH

1. There must be no more unaccountable block contracts for mental health.

2. Providers should never entirely be rewarded for providing a number of days of care within a particular setting, but instead be rewarded for delivering whole pathways of care with achievement of defined outcomes or meeting local population need, as appropriate.

3. Both national and local outcome measures should be used as part of the payment system, these should be co-produced and developed by all stakeholders with a leading role taken by people with lived experience of mental ill health (and their families).

4. Where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental health care, the payment approach should be embedded within the wider urgent and emergency care payment approach, and payment for mental health care within physical care pathways should be similarly integrated.

5. Payment approaches should include access standards, where these are developed, to drive achievement of improved access to timely, evidence-based care with routine outcome measurement.

6. Payment approaches should be developed with experts-by-experience, reward engagement and delivery of access to excellent care for particular groups, where this is appropriate. This may include BAME populations and people with co-morbidities, such as substance misuse or diabetes.

7. Outcomes should be holistic and reward collaborative working across the system (e.g. stable housing, employment, social and physical health outcomes).

8. Payment systems must promote transparency and increased provision of high quality, relevant data that can drive improvement.

9. Payment systems should support improved productivity, value, efficiency and reduced costs, where possible.

10. Payment systems should support pathways through services, rewarding and incentivising step down to lower-intensity settings and a focus on care in the least restrictive setting. They should aim to reduce avoidable crises, admission and detentions, while protecting against any misalignment of incentives that might give rise to cherry-picking or other risks that might impact negatively upon those people with mental health problems who are 'hardest to reach'.

11. National guidance should support commissioners to commission effectively using appropriate payment approaches.

12. Additional support should be provided to commissioners to build leadership, capacity and capability in commissioning services, including for the use of new payment approaches that will necessarily require new skills and competencies.

ANNEX B:

FULL RECOMMENDATIONS

Recommendations are listed by lead or joint lead agency for the NHS arms-length bodies

NHS ENGLAND	Future in Mind	NHS England should continue to work with HEE, PHE, Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping at least 70,000 more children and young people each year to access high-quality mental health care when they need it by 2020/21. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.
	Access standards and care pathways	By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, for the full range of mental health conditions based on the timetable set out in this report. These standards should incorporate relevant physical health care interventions and the principles of coproduced care planning, balancing clinical and non-clinical outcomes (such as improved wellbeing and employment). Implementation should be supported by: • Use of available levers and incentives to enable the delivery of the new standards, including the development of aligned payment models (NHS England and NHS Improvement) • Alignment of approaches to mental health provider regulation (NHS Improvement and CQC) • Comprehensive workforce development programmes to ensure that the right staff with the right skills are available to deliver care in line with NICE recommendations as the norm (HEE) • Ensuring that the relevant public health expertise informs the development of the new standards and that they are aligned with the new co-existing mental health and alcohol and/or drug misuse services guidance being developed for commissioners and providers of alcohol and/or drug misuse services. (PHE)

NHS ENGLAND	Perinatal mental healthcare	NHS England should invest to ensure that by 2020/21 at least 30,000 more women each year access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.
	Psychological therapies for people with long term conditions	NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.
	Employment support	By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see above) and doubling the reach of Individual Placement and Support (IPS). NHS England should seek to match this investment in IPS by exploring a Social Impact Bond or other social finance options.
	Early Intervention in Psychosis	NHS England should ensure that by April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.
	Crisis services	By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that a 24/7 community-based mental health crisis response is available in all areas and that these teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For children and young people, an equivalent model of care should be developed within this expansion programme.
	Acute liaison	By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum.

NHS ENGLAND	Least restrictive acute care	In 2016, NHS England and relevant partners should set out how they will ensure that standards – co-produced with experts by experience, clinicians, housing and social care leads – are introduced for acute care services over the next five years. Integral to the standards should be the expectation that acute mental health care is provided in the least restrictive manner and as close to home as possible, with the practice of sending people out of area for acute inpatient care due to local acute bed pressures eliminated entirely by no later than 2020/21. Plans for introduction of the standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17. NHS England and NHS Improvement should also ensure that use of the Mental Health Act is closely monitored at both local and national level, and rates of detention are reduced by 2020/21 through the provision of earlier intervention. Plans should include specific actions to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups in acute care.
	Secure care pathway	NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery and 'step down' for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and identify new co-commissioning, funding and service models. This work should also tackle inequalities for groups shown to be over-represented in detentions and lengthy stays, and seek to ensure that out of area placements are substantially reduced. The programme should identify where and how efficiencies could be realised within the system and reinvested, and include recommendations on the wider reforms required to make this happen, including changes to legal processes. NHS England should also roll out the proven model of teams delivering community forensic CAMHS and complex need services nationally from 2016.
	Using and sharing data	By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing datasets by no later than summer 2016.
	Vanguards	MCP, PACS, UEC vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions within new care model programmes. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

NHS ENGLAND	Physical health outcomes in people with mental illness	NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention. This will involve developing, evaluating and implementing models of primary care whereby GPs and practice nurses take responsibility for delivering the full suite of physical care screenings, outreach, carer training and onward interventions or referrals, in line with NICE guidelines. This model should include outreach workers or carer training to support people to access primary care because many people with psychosis struggle to access services, and give GPs and practice nurses the training and time they need to deliver NICE-concordant screening and care.
	Older age specialist services	NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national CQUIN or alternative incentive payments and embedded through the vanguard programmes.
	Trialling population based budgets	NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17 NHS England should also trial new models through a Vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements. We recommend testing this at scale, with a particular focus on secure care commissioning, perinatal and specialised CAMHS services.
	Co-production evaluation	NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.
	CCG inequalities – funding	NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and Primary Care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and mental health inequalities.
	NHS staff mental health	NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.

NHS ENGLAND	Navigators	NHS England and NHS Improvement should encourage providers to ensure that 'navigators' are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support. In parallel, NHS England and HEE should work with voluntary and community sector organisations, experts-by-experience and carers to develop and evaluate the role of 'navigators' in enabling more people-centred care to be provided.
	Trialling acute care models or 16-25s	NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with Vanguard sites. This should evaluate: developmentally and age-appropriate inpatient services for this group; supporting young people in an environment that maximises opportunities for rehabilitation and return to education, training or employment; viewing the young person within their social context; and enlisting the support of families or carers. This should build on the existing trials of new models of 'transitional' services for those aged 0–25.
	NHS staff awareness	NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.
	Staff health & wellbeing	NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.
	Data stocktake	NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary. For the most important data items (including inequalities data), commissioners should use NHS standard contract sanctions (financial penalty) for a data breach where there is persistent non-return of data. Commissioners should be required to use national data flows where they exist and not place undue pressure on providers by asking for local data that duplicates national data.
	Payment system	NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people's services as soon as possible.
	Governance	NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners.

Public Health England	Mental Health Intelligence Network	During 2016 NHS England and Public Health England should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.
	Preventing poor physical health outcomes	Public Health England should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.
	Preventing mental ill health	PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated JSNA and joint prevention plans that include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.
Care Quality Commission	Integrated regulation of CYP services	The CQC should work with Ofsted, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people's mental health outcomes.
	Quality inspection across settings	The CQC should develop regulation and inspection of NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups, beyond the inspection of providers. Within its strategy for 2016–2020, the CQC should also set out how it will strengthen its approach to: • How it inspects primary medical services, acute and adult social care services, so that it assesses whether these services are providing high-quality care for people with mental health problems • Inspect providers on the quality of co-production in individual care planning, carer involvement and in working in partnership with communities to develop and improve mental health services (drawing on good practice such as the 4PI principles) • Ensure that, from 2016, inspections of all specialist mental health services reflect the extent to which the provider ensures that people have an outcomes-focused recovery path that includes discharge and future planning and is integrated with other services, incorporating housing and other social needs · Ensure (with support from the Department of Health) that data captured about experience of inpatient mental health services is represented in a form which allows comparison and improvement monitoring at national level • Incorporates good practice in information sharing with other providers and with mental health carers, to address complex issues relating to how patient confidentiality rules apply in the care of people with mental health problems.

NHS Improvement	Learning from deaths by suicide	NHS Improvement and NHS England, with support from Public Health England, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements are learned from to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.
Health Education England	Workforce planning and development across settings	HEE should work with NHS England, PHE, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This review should address training needs for both new and existing NHS-funded staff and should report by no later than the end of 2016. This workforce strategy should include: • Clear projections for required staff numbers to 2020/21 and what action will be taken to plug any gaps • Core training in basic mental health awareness and knowledge, understanding of mental health law, public mental health, compassion and communication skills • For professions involved in the care and support of people with mental health problems, tailored curricula with competencies in dealing with the common physical health problems people may present with, shared decision-making, mental health prevention (including suicide), empowering people to understand their own strengths and self-manage, carer involvement and information sharing. Drawing on the best available evidence, this should also ensure that professionals are equipped to provide age-appropriate care and reduce inequalities. HEE and PHE should develop an action plan so that by 2020/21 validated courses are available in mental health promotion and prevention for the public health workforce (including primary care).
	Prescribing standards	HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, take into account people's personal preferences, include preventative physical health support and the provision of accessible information to support informed decision-making. This should be completed in collaboration with relevant stakeholders by April 2017 and subject to regular review.

RECOMMENDATIONS FOR GOVERNMENT

Cabinet office	Co-morbid mental health and substance misuse problems	The Cabinet Office should ensure that the new Life Chances Fund of up to £30m for outcomes-based interventions to tackle alcoholism and drug addiction requires local areas to demonstrate how they will integrate assessment, care and support to people with co-morbid substance misuse and mental health problems, and make a funding contribution themselves. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.
Department of Health	Research	The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now, setting out a 10-year strategy for mental health research. This should include a co-ordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.
	Equalities	The Department of Health should appoint a new equalities champion with a specific remit to tackle health inequalities amongst people with mental health problems and carers across the health and social care system and through cross-government action. This role should include responsibility for advising on operational activity within the NHS to reduce discrimination for people found to be at particular risk, including but not limited to those with characteristics protected by the Equalities Act. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health and this should form part of the remit of the new role-holder.
	Suicide prevention	The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health's annual report on suicide.
	Mental Health Act	The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.

Department of Health	Social work	The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding 'Think Ahead' to provide at least an additional 300 places.
	Supported housing	The Department of Health, Communities and Local Government, NHS England, HM-Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.
	Health and Justice care pathway	The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed. This should build on the national roll out of Liaison and Diversion schemes (including for children and young people) across England by 2020/21 and the increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment) as part of community sentences for everyone who can benefit from them. It should also improve mental health services in prison and the interface with the secure care system, with continuity of care on release, to support offenders to return to the community.
	Data improvement	The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to: address the need for substantially improved data on prevention, prevalence, access, quality, outcomes and spend across mental health services; set out responsibilities for each agency in providing the necessary legal, commissioning, and quality and safety information required; design and develop new datasets, linking physical health, mental health, social care and employment datasets, while ensuring that information governance adequately protects people's rights; include mental health measures in all physical care datasets, including emergency care. The HSCIC should act as a data system leader and set new minimum service expectations for turning around new datasets or changes to existing datasets. The Department of Health, NHS England, HSCIC and NHS Improvement should publish a summary progress report by the end of 2016 setting out how the specific actions on data, information sharing and digital capability identified in this report and the National Information Board's Strategy are being implemented.
	Children and Young People metrics	The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017.

Department of Health	Greater transparency	The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health FYFV Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include health and social outcomes including employment and settled housing outcomes for people with mental health problems.
	Prevalence surveys	The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every 7 years.
	CCG transparency	The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase. For children and young people, this should be broken down initially into spend in the community, on emergency, urgent and routine treatment, and for inpatient care.
	Parity for mental health in Health & Social Care Act regulations	The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated or to access care within maximum waiting times).
	Deaths in inpatient settings	The Department of Health should ensure that the scope of the new Healthcare Safety Investigation Branch includes a clear focus on deaths from all causes in inpatient mental health settings, including independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement. This should include the involvement of families, and build on the models and experiences of the Independent Police Complaints Commission and the Prisons and Probation Ombudsman. The Department should also work with the CQC to establish a methodology for inspecting the quality of learning from all deaths in inpatient mental health services, including introducing greater transparency around the cause of deaths within each provider.

Department of Health	Challenging stigma	The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community, to contribute to improving attitudes to mental health by at least a further 5 per cent by 2020/21.
	Innovation fund for devolved areas	The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).
	Digital	The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.
	New GPs	The Department of Health and NHS England should work with the RCGP and HEE to ensure that by 2020/21 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.
	Regulation of psychological therapies	The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless provided within secondary mental health services.
	Better Care Fund	To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health. This might include making an element of payment for outcomes contingent on reducing acute admission through requiring all hospitals to comply with Crisis Care Concordat and NICE standards on liaison and crisis mental health care.
	Summary Care Records	The Department of Health and HSCIC should advocate adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.

Department for Work & Pensions	Employment support	The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts. The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.
	Housing Benefit cap	The Department of Work and Pensions should, based on the outcome of the "Supported Housing" review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.
Department for Education / Department of Health / Department for Work and Pensions	Parenting programmes and support for children with complex needs	The Departments of Education and Health should establish an expert group to examine the needs of children who are particularly vulnerable to developing mental health problems and how their needs should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People's mental health services.
HEFCE	Research	HEFCE should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.
ACRA	Inequalities and funding allocation formula	ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

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