

Mental Health Financial Planning

Frequently asked questions

1. What is Mental Health Investment Standard (MHIS)? How is it calculated?

The Mental Health Investment Standard (MHIS) was previously known as Parity of Esteem (PoE) and is the requirement for CCGs to increase investment in Mental Health (MH) services in line with their overall increase in allocation each year.

The calculation of the MHIS is as follows:-

	1617 FOT MH Spend	1617 FOT MH Spend of NR Allocations	1617 FOT MH Spend for MHIS	1718 Planned Spend	Growth in Spend	CCG Programme Allocation Growth	POE Acheived?
MHIS Example	100,000	10,000	90,000	93,500	3.50%	3.40%	YES

For MHIS purposes, 1617 FOT excludes spend against NR MH allocations issued in year. The plan template adjusts for this. This adjustment is not required for the 17/18 or 18/19 MH spend as only spend against allocations included in baseline is included in plan.

1617 FOT MH Spend of Non-Recurrent Allocations (planning template cell F36) should include spend of the following allocations issued during 2016/17:-

- CYPMH Crisis & Liaison UEC Vanguard
- CYP Local Transformation Mental Health
- Any further allocations issued

This should not include:-

- Spend against the CYP allocation included in 16/17 baseline
- Spend against the 16/17 Eating Disorder allocation as this is included in baselines from 17/18 onwards.

2. Why is the MHIS being calculated including and excluding Learning Disabilities and Dementia?

In the plan template, we are calculating the MHIS both including and excluding spend on Learning Disabilities (LD) and Dementia.

The Mental Health Five Year Forward View excluded both LD and dementia recommendations, it is therefore important that we track the strategy and associated funding excluding spend on LD and dementia. We are measuring achievement of the MHIS both including and excluding LD and dementia to emphasise the importance of continuing investments across all 3 areas. We are aware that previously CCGs may have met the PoE targets only through increases in Dementia and LD spend which may have masked disproportionate growth in other areas of Mental Health spend.

CCGs are asked to provide explanation if they are not achieving the standard in either instance. However, from 17/18 onwards please be aware that performance against the MHIS is likely to be assessed excluding these categories of spend.

3. What if we are not achieving the MHIS?

If a CCG is not increasing spend on MH services in line with their growth in programme allocation (either including or excluding LD and Dementia services) then they must provide an explanation by selecting a reason code in column 1.

Reason Code	Description	Further Detail
1	Commissioners in deficit, not achieving 1% plan metric or with very low growth – in this case MH PoE will be measured against increase in overall planned spend, recognising that growth will need to support the improvement in the financial position	This applies where a CCG is considered financially challenged and maybe compromised in delivering on the MHIS. However, in this instance growth will be compared to the overall growth in planned spend (rather than allocation) to ensure that funding isn't being taken from mental health disproportionately. If the CCG cannot demonstrate this then this reason will not be accepted.
2	PoE achieved across health economy - please list CCGs that should be assessed together in free text	Where this reason is selected the CCGs should be listed in the free text box and the MHIS will be calculated across these CCGs. If the group of CCGs to not achieve the MHIS then this reason will not be accepted.
3	Historically high investment in mental health - where there is clear evidence that the commissioner is already a high spender on MH and any further investment would not deliver value for money. We will take into account performance against delivery standards.	In this instance we may look at growth over a number of years and will combine assessment of the MHIS with performance information (such as that included in the MH dashboard) to ensure that where a CCG has invested highly this is being reflected in operational performance.
4	Other - please provide further explanation in free text	If reason codes 1-3 do not apply then please select reason code 4 and provide further explanation in the free text. The explanation given will be considered by the regional / central teams and a decision will be made about whether it is accepted.

Where a commissioner fails to achieve the MHIS without a valid reason, NHS England may consider imposing directions on the CCG to increase its level of investment. This will be applied in exceptional circumstances where the caveats outlined above cannot be verified. Any actions will be discussed with regional teams.

4. We have high non-recurrent spend in 2016/17 which is skewing the MHIS calculation – should this be removed?

The Mental Health Investment Standard has always been calculated based on total spend. Non-recurrent spend should not be removed for this calculation as it is expected that investment in MH services will increase at the same level as the CCG allocation growth irrespective of whether spend is recurrent or non-recurrent (i.e. non-recurrent spend will be reinvested in MH). If the CCG will not achieve the standard because of non-recurrent spend then they can select the 'other' reason code and provide an explanation in the free text box which will be considered when plans are being assessed. Where CCGs are not achieving the MHIS in 17/18 plans we may consider the overall growth in investment over previous years and operational performance as with reason code 3.

5. Will the MHIS impact on our CCG Financial Assessment rating?

During 2016/17 we have developed a RAG rating system for the MHIS / PoE which has been used as part of the overall CCG Financial Assessment rating. We intend to continue using this RAG rating (further detail in the table below) to feed into any future assessments of the CCG financial position.

MENTAL HEALTH INVESTMENT STANDARD (MHIS) RAG RATING		
RED	AMBER	GREEN
MHIS not achieved and reason not accepted	MHIS not achieved and reason accepted	MHIS achieved

6. What should we include as MH spend / in each of the categories of spend?

As a general rule of thumb, please included any spend that would be categorised as Mental Health / LD for programme budgeting purposes. Spend on LD specific services should be included against the LD category only. Please ensure that you include all mental health spend in this table including spend against NR allocations in 2016/17 (this is adjusted for before calculation of the MHIS) and spend against additional MH funding included in baselines.

Please see table below for guidelines on what should be included in each of the categories:-

Children & Young People's Mental Health (excluding LD)	Spend to include services for children and young people's mental health across the whole care pathway, from early year's settings through to crisis care and intensive support as well as including the CYP IAPT programme. We ask CCGs to include spend for services in primary and community settings, including acute hospitals. As well as spend in NHS services, we ask CCGs to include CYP MH services commissioned from or delivered in local authorities, schools, Further Education Colleges and the voluntary sector. This should include both new resources allocated to CYP MH as a result of the <i>Future In Mind</i> investment from the Spring Budget 2015 which will rise each year to 2020, and existing resources spent on community and primary services.
Children & Young People's Eating Disorders	Spend on eating disorders for children and young people and their families/carers is for delivery of dedicated community eating disorder services in line with the evidence-based treatment pathway for ED (2015). They should be multidisciplinary teams that include medical and non-medical staff resourced to meet a range of presenting need from early to severe stage of illness and support consultations, treatment and working with universal services (GP, School, voluntary sector) and more intensive outpatient services (e.g. crisis, home treatment, day patient care).
Perinatal Mental Health (Community)	Spend for perinatal mental health treatment and care in a community setting to include services for detection, pre-conception counselling, proactive management, assessment, advice, intensive support and treatment for childbearing women experiencing, with a history, and/or at high risk of serious mental ill health who cannot be managed effectively by primary care services alone. Spend on services to include advice and assistance to primary care, maternity and other mental health services on the treatment and management of serious perinatal mental illness. We ask CCGs to include spend multi-disciplinary specialised perinatal community mental health teams including medical, psychological, nursing, and social care and support. We ask CCGs to include their spend associated with perinatal mental health support services when they work with partners including other NHS services, local authorities, and the voluntary sector and community sector. The Community Services Development Fund announced in November 2016 provides new resources for CCGs to collaborate in specialised perinatal mental health community services. CCGs accessing this funding who are working in partnership with a lead CCG are asked to identify the relative proportion of their spend from the total allocation and record the associated amount to demonstrate distribution of investment. The 'perinatal' period refers to the time of conception until 12 months after the birth of the child.
Improved access to psychological therapies (adult)	Spend against the Improving Access to Psychological Therapies (IAPT) only includes spend for these services: meaning all activity paid for under this line should be returned to the IAPT minimum data set.
A and E and Ward Liaison mental health services (adult)	This is the spend on distinct mental health liaison ('liaison psychiatry') specialist teams based on-site at acute hospitals with 24/7 A&E departments.

	<p>The specialist teams provide urgent and emergency mental health assessment and treatment to general hospital emergency departments and inpatient wards for adults of all ages.</p> <p>We are aware that some mental health liaison teams also work in outpatient departments as part of 'planned care' pathways – however this is not in the scope of this request and planned care should therefore not be included in this tracker. Where the same liaison mental health team provides both planned (outpatient) and unplanned (A&E and inpatient) care, best estimates should be made about spend on unplanned care pathways.</p> <p>Some liaison teams are commissioned from mental health providers; some from acute providers and some from a combination of both. Spend on all these different types of liaison contracts should be included.</p> <p>This spend does not include community-based crisis resolution home treatment teams that provide in-reach mental health crisis care to general hospitals This spend is included in a separate spend category on crisis resolution home treatment.</p>
<p>Early intervention in psychosis 'EIP' team (14 - 65)</p>	<p>This spend relates only to specialist EIP teams that have been commissioned to provide the full range of psychological, psychosocial, pharmacological and other interventions shown to be effective in NICE guidelines and quality standards, including support for families and carers. Early Intervention in Psychosis services also triage, assess and treat people with an 'at risk mental state' (people at high risk of developing psychosis), as well as help those not triaged to access appropriate treatment and support.</p> <p>This spend relates only to specialist EIP teams. Spend on 'EIP activity' in generic community mental health services should not be counted.</p>
<p>Crisis resolution home treatment team (adult)</p>	<p>This spend is associated with crisis home resolution treatment teams (CRHTTs) that exist in all areas providing the functions of initial urgent and emergency mental health response in communities, usually to people's homes – as well as intensive home treatment for a time limited period as an alternative to inpatient mental health admission. In most cases, one team provides both functions of community crisis response and ongoing home treatment. However, in some areas these functions will be separated – with separate teams providing the urgent and emergency mental health response (immediate assessment and treatment) and the ongoing home treatment. In these instances, the spend on the teams providing both of these functions should be combined.</p> <p>This spend relates only to specialist CRHTT services. Spend on 'CRHTT activity' in generic community mental health services should not be counted.</p>
<p>Community Mental Health</p>	<p>Community mental health services comprise multi-disciplinary teams offering specialist assessment, treatment and care to adults with mental health problems in their own homes and in the community.</p> <p>Spend under this category should include spend on:</p> <ul style="list-style-type: none"> • Assessment and brief intervention teams • Recovery teams • Community rehabilitation teams • Assertive outreach teams • Community mental health teams – for adults and older adults • Embedded employment support such as Individual Placement and

	<p>Support for people under the care of the CMHT</p> <ul style="list-style-type: none"> • Specialist primary care mental health provision for people with mental health problems (excluding IAPT) • Community mental health care and support commissioned from the voluntary / independent / third sector
SMI Physical Health	<p>This category of spend is intended to cover CCG commissioned activity to deliver a comprehensive, NICE recommended physical health assessment and follow up intervention (as required), for people with severe mental illness (SMI), across both primary and secondary care settings:</p> <ul style="list-style-type: none"> • the proportion of spend across inpatient and community mental health settings designated for physical health assessments and follow up interventions for people with SMI • specific clinics or services for delivering physical health checks and follow up interventions for people with SMI, whether based in primary or secondary care settings. For example, this service may be delivered via an enhanced primary care service commissioned by the CCG. • outreach and peer support to ensure people with SMI are supported to engage with physical health care services and support • workforce development and training of teams across primary and secondary care <p>This category of spend is not intended to cover the entirety of the provision to improve physical health care for people with SMI. For example, it is recognised that it will not include:</p> <ul style="list-style-type: none"> • Local authority spend on preventative and public health services such as smoking cessation support for reducing premature mortality amongst people with SMI
Suicide Prevention	<p>This spend to include:</p> <ul style="list-style-type: none"> • Specific NHS-based suicide prevention initiatives relating to mental health patient safety in primary care, inpatient or community settings • Any spend contributed by CCGs to wider local suicide prevention work led by public health teams in local authorities.
Dementia	<p>Spend on people living with dementia and their carers to include activities that correspond to a range of presenting needs from early stage intervention to more intensive support in primary care, community, outpatient and inpatient settings. Spend to include services against the five elements of the well-pathway preventing well, diagnosing well, supporting well, living well and dying well. For preventing well this would include activities such as health checks, prevention awareness raising and risk reduction. For diagnosing well this would include Memory Assessment Services, regardless of how delivered i.e. primary, secondary, community care, activities to screen people for potential dementia assessment, and activities to set up an initial care plan. For supporting well this would include appropriate post-diagnostic support such as follow-up care plan reviews, psychological therapies for both the person with dementia and their carers where appropriate. For living well this should include carers' support e.g. respite; community engagement e.g. dementia friends. For dying well this should include palliative care and pain management. We ask CCGs to include spend where CCGs work with partners in the community to deliver services including the voluntary sector.</p>
Other adult mental health	<p>This spend to include :</p> <ul style="list-style-type: none"> • Acute inpatient services – Defined as acute beds for male and female adults to provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness. • Acute Day Care Services – these usually act as a step up/down service from inpatient care as part of the acute mental health pathway. The

	<p>services usually offer assessment, treatment activities and care planning for a time-limited period.</p> <ul style="list-style-type: none"> • Psychiatric intensive care units (PICU) - Psychiatric intensive care for compulsorily detained patients of adult working age who are in an acutely disturbed phase of a serious mental disorder. These wards are secure, meaning that they are locked and entry and exit of patients is controlled. Staffing levels are usually higher than on an acute inpatient ward, usually multi-disciplinary and sometimes with 1:1 nursing staffing ratios. • Longer-term complex care/continuing care units - For patients with high levels of disability including those with co-morbidity who have limited potential for future improvement and continue to pose significant risk to their own health or safety, or to that of others. Such units can be community or hospital based and domestic services are provided. • Older Adult inpatient services - For the psychiatric care of older patients on older adult mental health wards who are living with frailty alongside a functional mental illness (for example psychosis, affective and behavioural disorders) including complex co-morbidities. This spend does not include care and treatment for adults with dementia. • Any CCG commissioned independent sector provision for adult mental health services, including spend on Out of Area Placements (OAPs) • Any CCG commissioned voluntary sector provision (for example Crisis house) for adult mental health services.
<p>Primary care prescribing on mental health drugs</p>	<p>Spend on primary care prescribing on mental health drugs should be in line with NICE guidance, or (where available and appropriate) in line with recommendations from Regional medicines optimisation committees. We ask CCGs to specify whether spend is NHSBA EPACT system actual costs or NIC (net ingredient costs).</p> <p>Spend to include the following therapeutic areas where total spend is the sum of:</p> <ol style="list-style-type: none"> 1) Hypnotics and anxiolytics (BNF legacy 4.1 or equivalent therapeutic class defined by the BNF) (excludes pregabalin) <ol style="list-style-type: none"> a. Include an estimate of spend for pregabalin when used as an anxiolytic only 2) Drugs used in psychosis and related disorder <ol style="list-style-type: none"> a. Oral antipsychotic drugs (BNF legacy 4.2.1 or equivalent therapeutic class defined by the BNF) (excluding prochlorperazine) b. Depot /Long acting antipsychotic drug (BNF legacy 4.2.2 or equivalent therapeutic class defined by the BNF) c. Drugs used for mania & hypomania (BNF Legacy 4.2.3 or equivalent therapeutic class defined by the BNF) (excluding carbamazepine and sodium valproate) <ol style="list-style-type: none"> i. Include an estimate for carbamazepine and sodium valproate when used for mania /hypomania (excludes use in other conditions) 3) Antidepressant drugs (BNF Legacy 4.3 or equivalent therapeutic class defined by the BNF) Excluding amitriptyline and nortriptyline <ol style="list-style-type: none"> a. Include an estimate of spend for amitriptyline/nortriptyline when used as an antidepressant 4) CNS stimulants and drugs used in the management of hyperactivity disorder (BNF Legacy 4.4 or equivalent therapeutic class defined by the BNF) 5) Drugs used in the management of dementia (BNF legacy 4.11 or equivalent therapeutic class defined by the BNF)

As in previous years, we recognise that service models vary across the country and so ask that CCGs split their spend as best they can given the information that they have available. The categories are aligned to the MH Five Year Forward View and Implementation Plan and so these documents can be also used as a guide (see Q12 for more info)

7. What if we have excluded spend in previous returns (16/17 plan, non-ISFE returns) that should have been included?

Irrespective of information previously returned, please ensure that this plan return is as complete as possible and includes all spend that is deemed appropriate given the guidance. Checks will be done comparing your plan template to your latest non-ISFE return and material differences may require some explanation.

8. What is the difference between 'core mental health' and 'mental health in other areas'?

Core Mental Health Spend - the spend that is included on the financial plan detail worksheet under the Mental Health Services heading. There is a validation check on the Mental Health worksheet which checks that the totals match – please ensure that this validation is cleared before submitting your template.

Spend on Mental Health in Other Areas – is any spend on Mental Health services that is under another heading on the financial plan detail worksheet, for example acute or community services and Continuing Health Care.

9. What should we do if we do not commission services in one or more of the categories?

If you do not commission services in one or more of the categories then please submit a zero plan for those categories and select N/C (not commissioned) from the drop down in column H.

All categories with a zero plan should have either N/C or N/A (see below) selected so that we can identify the reasons for low return rates in specific categories.

10. What should we do if we are not able to split out spend for one or more of the categories? It is wrapped up in a block contract.

If you are not able to split out spend in one or more of the categories (but it is a service that your organisation commissions) then please submit a zero plan for those categories and select N/A (not available) from the drop down in column H. Please ensure that this spend is then included against the next most appropriate category or 'other' – do not exclude the spend.

However, please endeavour to split out spend for all commissioned services into the most appropriate categories. If exact splits are not available then an estimate is preferred to a zero return.

All categories with a zero plan should have either N/C (see above) or N/A selected so that we can identify the reasons for low return rates in specific categories.

11. Spend on Out of Area treatments (columns N / O) – is this just high cost patients or is this all OOA treatments?

This should include spend for all out of area treatments.

12. Where can I find more information on the Mental Health Five Year Forward View / Implementation Plan?

MHFYFV - <https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf>

MH Implementation Plan - <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf>

13. Why do we need to split out spend on implementing the Five Year Forward View for Mental Health?

We have previously tracked spend against individual allocations but as these have progressively moved into CCG baselines it has become more difficult to split out the spend in this way. Going forwards we will look increasingly at the growth in spend in the relevant categories but feel that it is important that CCGs can highlight the additional investment that they are making to achieve the specifics of the FYFV. We are currently developing how we will monitor this spend as part of in year reporting.

14. What element of the MH taskforce funding has / will be included in CCG baseline allocations? Is this available split by CCG?

The following table details MH Taskforce funding included in CCG baselines for the 3 years 2016/17 – 2018/19. In addition there are, a number of other national service initiatives for which non-recurrent allocations will be actioned in year. Further information can be found in the Mental Health Implementation plan.

Policy Initiative	Implementation plan chapter no.	16/17	17/18	18/19
		£m	£m	£m
CYPMH	2	119	140	
Eating Disorders	2	*	30	30
Adult IAPT	4			35
MH new policy **	5		64	40
Total		119	234	105

Note:-

*Eating disorders funding allocated non recurrently in 16/17

**MH new policy initiatives includes EIP, Crisis home treatment, Community MH and SMI

(£m)	Gross costs					Gross savings					Net costs				
	2016/17	2017/18	2018/19	2019/20	2020/21	2016/17	2017/18	2018/19	2019/20	2020/21	2016/17	2017/18	2018/19	2019/20	2020/21
CYP mental health*	235	235	235	235	235						235	235	235	235	235
Eating disorders	30	30	30	30	30						30	30	30	30	30
IAPT access to 25%	20	88	157	233	308						20	62	35	-3	-56
Mental health Liaison (50% of hospitals)		15	30	84	120							15	15	54	36
Crisis Response Home Treatment Teams		43	90	140	146							43	26	5	-22
Perinatal mental health**	15	30	60	105	140						15	30	60	105	140
EIP to 60%		11	20	30	70							7	12	18	50
Community mental health			13	33	50								13	33	50
SMI physical health		41	83	83	83							14	2	-25	-25
Secure services transition fund		1	5	30	58							1	5	30	58
Liaison and diversion	5	12	17	27	31						5	12	17	27	31
Suicide prevention			5	10	10								5	10	10
Total	305	506	745	1040	1281	-57	-290	-521	-744	305	449	455	519	537	

Red = in CCG allocations

*Only a proportion of CYP is in allocations - this equals

**Of the 19/20 and 20/21 funding 70% is in CCG allocations

The table above gives shows national costing of the implementation set out in the Mental Health Five Year Forward View and the expected savings over the period. The numbers in black text relate to funding centrally held within the transformation fund portion of the sustainability and transformation fund (STF). The numbers in red text are included within CCG allocations for period to 2020/21.

This information is not available at a CCG level. Costings are done at a national level and it is for CCGs to determine locally the spend required to deliver the standards set out in the FYFV based on their baseline performance, prevalence etc.

15. Will we be monitored against this plan during the year?

Yes, CCGs will be monitored against their Mental Health plan during the year via regular non-ISFE returns.

16. Will this information be available publically?

As per 2016/17, planned and actual spend information will continue to be published in the Mental Health dashboard at a CCG level. This will include spend on individual categories as set out in the plan template.

The current dashboard can be found here: - [Link to MH dashboard](#)

17. What checks should we do when completing the MH template?

- If you are not achieving the Mental Health Investment Standard (either including or excluding LD/Dementia) ensure that you have selected a reason code and provided additional explanation where required.
- Ensure values are entered in thousands.
- Compare the 16/17 FOT total spend to your latest non-ISFE return for Mental Health and ensure that there is a legitimate reason for any material differences (e.g. spend previously excluded that should have been included)
- Ensure that all Mental Health spend is included in the "Spend by Category" table including spend of any additional funding included in CCG baselines or issued in year (for 2016/17).
- Ensure that cell F36 includes 16/17 spend of additional MH allocations issued in year so that this can be deducted for calculating the MHIS
- Ensure that if there is zero spend in any of the categories either N/A or N/C is selected in column H.
- Complete columns K & L are completed to show investment relating to implementing the MHFYFV (this is a memo – this spend should also be included in the main table)
- Complete columns N & O to show spend on Out of Area treatment (this is a memo – this spend should also be included in the main table)
- Clear all template errors