BMA

Beyond parity of esteem – Achieving parity of resource, access and outcome for mental health in England

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Summary of recommendations

Funding

1. Adequate funding should be made available to CCGs (Clinical Commissioning Groups) to allow them to double mental health spending over the period of the Long-Term Plan, alongside increased investment in primary care, public mental health, mental health research and the mental health estate.
2. NHS England should introduce a new 'CAMHS (Child and Adolescent Mental Health Services) Investment Standard' for CCGs, to ensure that commitments in the Long-Term Plan to increase funding for these services are met.

Access

3. Proposed NHS access standards for mental health[1] must come with adequate resourcing for them to be delivered.
4. Mental health trusts that have high numbers of monthly out-of-area placements should undertake reviews and develop plans for how to eliminate them by 2021.

Workforce

5. Mental health workforce commitments must be realistic and measurable.
6. Alongside the Royal College of Psychiatrists, Health Education England should deliver targeted recruitment campaigns for the higher training sub-specialties which have the lowest fill rates, such as old age psychiatry and learning disability psychiatry.
7. Mental health staff should be given better access to ongoing training for mental health and time for reflective practice, as well as health and wellbeing support.

Prevention

8. A cross-government joint strategy on improving public mental health should be developed.
9. National and local government and NHS bodies should take a 'mental health in all policies'[a] approach to policy making, by undertaking a mental health impact assessment of all new policy proposals.
10. Specific funding should be allocated to local authorities, in order for them to substantially increase spending on public mental health.

In recent years, there has been an encouraging policy focus on mental health in England. The 2016 Five Year Forward View for Mental Health included some welcome commitments, many of which have already resulted in positive developments.[2] For example, there has been improved provision in services such as perinatal mental health and EIP (Early Intervention in Psychosis), as well as improved mental health data tracking. More recently, the NHS Long-Term Plan set out further ambitions to improve mental health care in England,[3] including a commitment to increase funding by at least £2.3 billion a year by 2023/24, which has been set aside specifically for mental health.[4]

a Mental health in all policies is an approach to promoting mental health and wellbeing through ensuring mental health is considered within different non-health public policy areas.

However, doctors remain extremely concerned about the state of mental health services and the ability to deliver on some key ambitions. Mental health services remain a long way behind most physical health services in terms of their resourcing, patients' ability to access care and overall patient outcomes. For example:

- In England, just under a third of children with mental health problems are able to access the care they need.[5]
- In England, people with a severe mental illness die on average 15 to 20 years earlier than the general population.[6]
- In the UK, suicide is the leading cause of death among young people aged 20-34 years, and for men aged under 50.[7]

While recent NHS England and government commitments recognise the importance of parity of esteem between physical and mental health, it is vital that there is continued progress towards achieving parity of resource, access and outcome for people with mental health problems.

Box 1.

What does true parity look like?

Building on the BMA's vision for mental health:

- Parity of resource should ensure that mental health services receive adequate resources to meet the needs of the population, and to provide safe, effective and humane care.
- Parity of access should ensure patients with mental health problems are able to access effective, safe care in a timely manner and close to home, as much as those with physical health problems.
- Parity of outcomes should ensure that patients accessing mental health services have relatively good/comparable outcomes compared to those using physical health services, such that they are able to recover or improve their condition and have a better quality of life.

Realising parity of resource, access and outcome for mental health in England requires action across a range of areas, including funding, access, workforce and prevention – explored in more detail below.

Funding

Policy ask:
Adequate funding should be made available to CCGs (Clinical Commissioning Groups) to allow them to double mental health spending over the period of the Long-Term Plan, alongside increased investment in primary care, public mental health, mental health research and the mental health estate.

Recent years have seen some increased funding allocated to mental health, as part of the commitments to parity of esteem. CCGs (who receive the largest share of mental health funding) spent 13.8% of their total budget allocation on mental health services in 2018/19.[8] This was an increase from 13.1% in 2015/16.[8] While this is an increase, it is modest and does not go far enough in reversing the historical underinvestment in mental health compared to physical health services and delivering true parity of resource.

The staff working in the NHS are well aware of how much needs to be done to address this shortfall and begin to meet demand. In 2019 the BMA asked healthcare professionals working in mental health, whether they agreed there was parity of resource between physical and mental health, with 23% of respondents disagreeing and 56% strongly disagreeing.[9] Similarly, 72% strongly disagreed that changes to funding levels over the last two years had been sufficient to meet demand – mental health problems account for the single largest burden of disease in the UK (approximately 28%).[10]

Nine out of ten adults with mental health problems are currently managed in primary care.[11] The BMA believes that at least 11% of the total health budget should be invested in general practice[12] – currently it is around 8.1%. For mental health, this increased funding could ensure more mental health workers being employed within GP practices in a preventative approach, which should also be supported by further investment in public mental health. It could also help ensure that other parts of the primary care workforce that support mental health are fully staffed (such as health visitors and nurses) and promote further investment in social prescribing schemes.

Primary care is not the only area where investment is needed to reverse this historical underfunding. Another area is the mental health estate, where care is often provided in dated and inappropriate buildings. A 2018 Care Quality Commission report found details of numerous safety incidents related to poor infrastructure.[13] Despite this, investment in the mental health estate has often been neglected - for example, in the recent NHS capital investment programme.[14] As recommended by Sir Simon Wessley's review of the Mental Health Act, there should be increased investment in the mental health estate such that patients are provided with dignified and humane surroundings while they receive mental health treatment, that is conducive to their recovery.

Finally, it is important that funding for mental health research is increased. Currently only £9 per person affected by mental illness is spent each year, which has remained relatively unchanged in the last decade.[15] This contrasts to cancer research for example, where total spending equates to £288 per person affected.[16]

Policy ask:
NHS England should introduce a new 'CAMHS Investment Standard' for CCGs, to ensure that commitments in the Long-Term Plan to increase funding for these services are met.

Historical underfunding and increased pressure have placed CAMHS under significant pressure and struggling to meet demand in recent years. We therefore welcome the commitment in the Long Term Plan that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.[3]

The BMA's 2018 report *Lost in Transit* found significant variation in changes to CCG spending on CAMHS.[17] The Mental Health Investment Standard - which required all CCGs to increase their total mental health spend at the same rate as their overall budget increase – has demonstrated the impact an investment standard can have on delivering against funding commitments.[8] Replicating this for CAMHS would help to ensure that the promised uplift in funding is directly spent on CAMHS services. We would also recommend that, as with the Mental Health Investment Standard, the number of CCGs meeting a new 'CAMHS Investment Standard' should be recorded on the Mental Health Dashboard, to allow progress to be monitored.

Access

Policy ask:
Proposed access standards for mental health[18] must come with adequate resourcing for them to be delivered.

Some of the first access standards in mental health services were established in the Five Year Forward View.[2] These standards related to waiting times for those accessing IAPT (Improving Access to Psychological Therapies) services, and for those experiencing a first episode of psychosis to start treatment. These standards have already been met or are on track to be met by 2021.[17] This has resulted in more people with mental health problems accessing the care they need in a timelier manner, moving us closer to parity of access. However, there are still lengthy waiting times for many services, including for talking therapy[19] and for access to CAMHS.[20] As well as highlighting the view of mental health professionals that there is not parity of resources, a 2019 BMA survey found that 48% strongly disagreed, and 28% disagreed, that there is parity of access between mental and physical health services.[9]

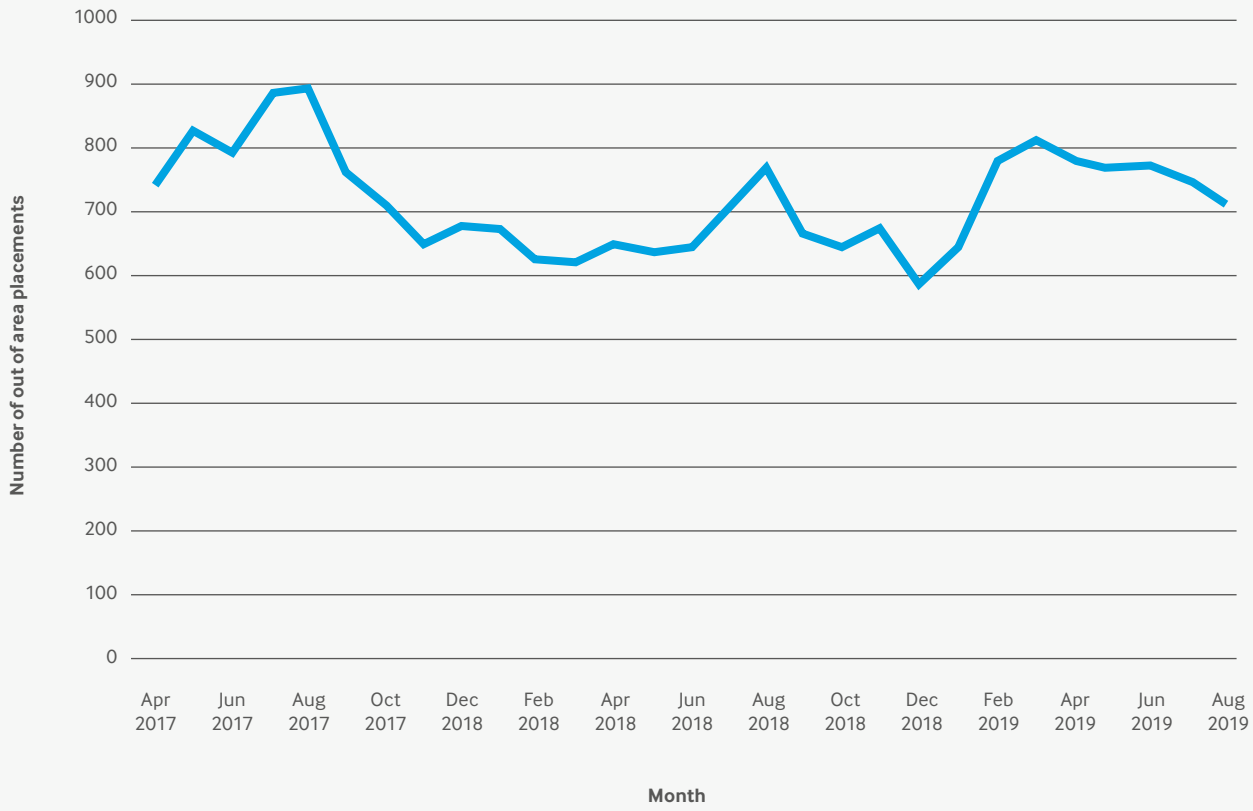
New access standards for mental health have now been proposed for crisis services, CAMHS, and adults and older adult community mental health teams as part of a wider clinical review of NHS access standards.[17] This is welcome, but it is vital that they are properly resourced, in order to meet the standards.

Funding commitments should also extend to evaluation and research, to help to understand the impact that access standards are having in pilot areas.[21] For example, the standards should not affect clinical judgement or reduce the quality of other aspects of care. They should not lead to the neglect of other mental health services due to resources being reprioritised to meet those standards. The BMA's 2018 report, Lost in Transit, found that funding for IAPT services had been prioritised over psychological therapies in secondary care, which may have been driven by the need to meet the IAPT standards.[16] Since the introduction of the IAPT access standard, 89% of people are now accessing IAPT within the 6-week waiting time. Whereas the BMA's research indicated that there were long delays in waiting times for psychological therapies in secondary care.[22]

Policy ask:
Mental health trusts that have high numbers of monthly out-of-area placements should have reviews undertaken, to develop plans for how to eliminate them by 2021.

It is widely accepted that sending patients out of area for acute inpatient mental health care is both worse for health outcomes and also costly for the NHS. The Five Year Forward View for Mental Health set a target of eliminating these out-of-area placements for adults in acute inpatient care in England by 2020/21.[2] However NHS Digital data show that there has been no sustained progress in eliminating out-of-area placements over the last two years (**see figure 1**).[23] The most recent data show there were 710 inappropriate out-of-area placements in August 2019, with 305 patients in England having to travel 100-200km to access a mental health bed.[24]

Figure 1 – inappropriate out of area placements, April 2017 to August 2019



Reviews should be undertaken for Mental Health Foundation Trusts, Mental Health Non-Foundation Trusts and Independent Sector providers that have continuously high numbers of out-of-area placements, to develop robust plans for how to eliminate them by the end of 2021. More support should be put in place for those that are failing to reduce their out-of-area placements. These efforts should also sit alongside increased investment in bed capacity, to ensure there are sufficient beds for every patient requiring one, including mental health rehabilitation beds.

In July 2019, BMA research highlighted wider issues with out of area placements for patients accessing mental health rehabilitation services. A series of responses to Freedom of Information requests documented the NHS' reliance on private hospitals and care homes for providing rehabilitation facilities, hours away from patient's homes. Again, this is associated with poorer health outcomes and increased costs to the NHS. Yet despite this, there are currently no national targets to reduce or eliminate out of area placements for mental health rehabilitation beds. It is therefore vital that reviews of out-of-area beds consider rehabilitation beds as well as those in acute inpatient care and identify appropriate actions to tackle this problem.

Workforce

To see the BMA's full analysis and recommendations for the mental health workforce, see the *BMA's briefing on the Mental health workforce in England*. A brief summary is provided below.

In 2017 HEE published *Stepping forward to 2020/21, a mental health workforce plan for England*, along with various commitments to expanding the mental health workforce. BMA analysis indicates that many of the workforce commitments within Stepping forward to 2020/21 are not on track to be met. For example, around 12% of all medical vacancies are within mental health, and vacancy rates for the medical workforce remain largely unchanged over the past few years. There must be sustained focus on filling vacancies across the mental health workforce, with a focus on filling consultant psychiatric posts in areas with the highest vacancy rates, such as in eating disorders and perinatal mental health.

Policy ask:
Mental health workforce commitments must be realistic and measurable.

Although the recent commitments to expand the mental health workforce are welcome, such as those in Stepping forward to 20/21 and more recently in the NHS Mental Health Implementation Plan 2019/20 – 2023/24, these commitments need to be realistic and measurable. This can be achieved through more robust and frequent data collection and reporting of the mental health workforce, including for areas where there has been little data collection, such as the IAPT workforce, other mental health therapists, and across the voluntary/private sector.

To help to inform workforce planners locally and nationally, there should also be stronger commitments to reporting progress against timelines such as the planned workforce expansions in the Mental Health Implementation Plan. These steps will help workforce planners to understand which areas need urgent attention.

Policy ask:
Alongside the Royal College of Psychiatrists, Health Education England should conduct targeted recruitment campaigns for the higher training sub-specialties which have the lowest fill rates, such as old age psychiatry and learning disability psychiatry.

The Royal College of Psychiatrists has undertaken a successful recruitment campaign called 'Choose Psychiatry'[25] which has resulted in an increase in doctors choosing to train in the speciality. Ensuring that medical school courses have more exposure to psychiatry throughout training would also help to increase the number of doctors choosing to train in psychiatry.

Once doctors reach a higher level of training, there are certain sub-specialties which have particularly low fill rates,[9] including old age psychiatry and psychiatry of learning disability. Alongside the RCPsych, HEE should undertake targeted recruitment campaigns for the higher training sub-specialties that have the lowest fill rates, to help to boost recruitment.

Policy ask:
Mental health staff should be given better access to ongoing training for mental health and time for reflective practice, as well as health and wellbeing support.

The 2019 BMA survey of mental health professionals found there has been both a reduction in access to ongoing training for mental health staff and in the time available for reflective practice.[9] Investment in training for mental health professionals must be a continued priority, as commitments within the mental health workforce plan are having little impact in this area.[9] Allowing clinicians the time to undertake these training opportunities must be factored into workforce and rota planning. This should also include primary care, as 50% of mental health staff surveyed (including GPs) stated that access to training (including enhancing primary care skills and training around mental health promotion) has worsened or greatly worsened.[9] We recommend that primary care staff have access to basic training in mental health through local training hubs.

To improve retention, staff must be supported by their employers to ensure that they are given sufficient time for reflective practice. This will also improve service delivery, as clinicians will be able to update their training, have the time to evaluate service design and undertake research opportunities. Retention can also be improved by ensuring all mental health staff have access to health and wellbeing support, and to occupational health services.

The BMA sets out a range of recommendations to improve doctors' mental wellbeing at work in our 2018 report Supporting health and wellbeing at work. Employers should also sign up to the BMA's mental wellbeing charter.

Prevention

Policy ask:
A cross-government joint body should be established to develop a joint strategy on improving public mental health.

To improve public mental health, comprehensive action is required on the social determinants of mental health - the conditions in which people are born, grow, live, work and age.[26] Policies which affect the social determinants of mental health are developed across many different and separate parts of government. The establishment of a cross-government body, and subsequent development of a strategy, would help to coordinate the joint action required across government and society to improve public mental health. This should have cabinet-level representation to ensure its success.

Policy ask:
National and local government and NHS bodies should take a 'mental health in all policies' approach to policy making, by undertaking a mental health impact assessment of all new policy proposals.

Across national and local government, there is often inadequate consideration given to the negative impact that wider policy changes or cuts to services can have on mental health. As part of a wider 'health in all policies' approach to policy making, policy makers should take a 'mental health in all policies' approach, by undertaking mental health impact assessments before implementing any significant new policies. This will help to encourage policies that promote mental health whilst preventing policy implementation that may have an adverse impact on public mental health.

Policy ask:
Specific funding should be allocated to local authorities, enabling them to substantially increase spending on public mental health.

The 2018 BMA report *Tackling the causes – promoting public mental health and investing in prevention* found that, although there is some investment in promoting public mental health, spending is far from optimal.[27] In 2018, local authorities in England spent less than 1.6% of their total public health budget on public mental health, with some reporting no spending in this area.[26]

Much greater investment is required in local public health services that are aimed at promoting mental health, as well as greater clarity about the role and expectations of local authorities in providing these services. It is also vital that recent cuts to public health funding, which have totalled £850 million in real terms since 2015/16,[28] are reversed. The government must commit to increased long-term funding for public health that properly meets the needs of local populations. Cuts to public health services can often have a disproportionate impact on people with mental health problems, for example by affecting substance misuse and smoking services.

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