



THE MENTAL HEALTH POLICY GROUP

REPRESENTATION TO 2020 COMPREHENSIVE SPENDING REVIEW

ABOUT THE MENTAL HEALTH POLICY GROUP (MHPG)

The Mental Health Policy Group is an informal coalition of six national organisations working together to improve mental health, comprised of the Centre for Mental Health, Mental Health Foundation, NHS Confederation Mental Health Network, Mind, Rethink Mental Illness and the Royal College of Psychiatrists.

Together we represent providers, professionals and the hundreds of thousands of people who use mental health services, and advocate for cross-government approaches to improve services and support early intervention and prevention of mental health problems.

OVERVIEW

We welcome the Comprehensive Spending Review (CSR). Our representation focuses on two CSR priorities:

1. improving outcomes in public services, including supporting the NHS
2. improving the management and delivery of our commitments

1. IMPROVING OUTCOMES IN PUBLIC SERVICES INCLUDING THE NHS

1.1 The NHS has faced unprecedented challenges during COVID-19. For mental health services, it has been a difficult balance between infection control and providing support and care. Surveys by our organisations show that three-quarters (79%) of people with pre-existing mental illnesses reported that their mental health had got worse or much worse as a result of the pandemic, with 42% saying their mental health was worse because they were getting less support from mental health services.ⁱ There are signs too that mental ill health may be on the rise in the general population too. The Office for National Statistics (ONS) shows that almost one in five adults in Britain experienced depressive symptoms in June 2020, which is approximately twice the number before the pandemic.ⁱⁱ

1.2 We strongly support the vision in the NHS Long Term Plan and the investment that underpins it of at least £2.3bn per annum by 2023/24. However, the worsening health of people with pre-existing mental health conditions coupled with more people experiencing mental ill health or a deterioration in wellbeing requires an acceleration of the funding promised in the NHS Long Term Plan for the expansion of mental health services in England. Further funding will be required to meet the increased need arising from the crisis. Early modelling by some providers and commissioners suggest that they can expect an increase in demand of 30 percent, although this hides variation between services. It is estimated that half a million more people likely to experience mental health problems as a result of the economic impact of the pandemic.ⁱⁱⁱ **The funding envelope promised in 2019 to implement the Long Term Plan cannot be stretched further than was intended.** After decades of underfunding, improving outcomes in NHS mental health services relies on a funding

settlement that is commensurate to demand. **Particular priority must be given to community mental health and social care services to ensure as many people as possible can stay well at home.**

1.3 Rethink Mental Illness supported the Institute for Public Policy Research (IPPR) to calculate for the first time the cost of achieving parity of esteem. By modelling how much it would cost to have similar rates of access to mental health treatment as physical disease, the price tag for parity of esteem was calculated as an additional £4.1bn by 2023/24.^{iv} We welcome the £2.3bn boost from the Long Term Plan, but we now need the **remaining additional £1.7bn for NHS mental health services committed by 2023/24 to get more people the right treatment at the right time, with an ambition for mental health services to receive at least £23.9bn by 2030/31.**

1.4 As we move out of national lockdown, reintroducing face to face mental health support in the community must be a priority given how many people struggled with virtual interventions. We welcome the funding pledged already for Personal Protective Equipment (PPE) and expect that this includes costings to fully equip mental health staff with the PPE needed to do their jobs effectively and safely. Given pent up demand and the need to maintain social distancing, some virtual interventions will continue to be necessary. This should be used as an opportunity to learn from the pandemic, to improve patient care (e.g. choice to have therapy remotely or in person) and workforce (e.g. increased flexibility) through digital technology and remote working. Improved technology also has benefits for system efficacy. For example, the majority of Mental Health Act related activity was formerly carried out using paper-based systems, including forms for assessment, medication or leave. The Independent Review of the Mental Health Act found that digital enablers could provide patients with a modern and consistent way to access information about the Act, their rights, safeguards and treatment processes.^v

In order to maximise the benefits that using technology can bring, providers must have adequate equipment. When asked to assess the equipment available to conduct duties remotely during the COVID-19 pandemic, only 19.7% of psychiatrists in England (257 of 1,303) felt they were 'fully equipped' with a further 38.3% (499) responding that they were 'well-equipped'. At the other end of the scale, 4.35% confirmed that their current IT equipment left them 'unequipped to conduct most/all duties' and 10.24% unequipped to conduct some duties.^{vi} **To remedy this, £135m of capital funding should be made available to mental health trusts for IT infrastructure with a further £65m allocated to the Global Digital Exemplar and Digital Aspirant programmes by 2024/25.**

It is important to acknowledge the significant risk of digital exclusion among patients, and how technology is not always accessible to all or designed with the users at its centre. **A 'blended' approach of face-to-face, remote and digital services, ensuring support exists for people who cannot access remote or digital communication or for whom this doesn't work should be adopted. A new Mental Health Innovation Fund should be established to look at new and inclusive digital interventions, underpinned by £50m over four years.**^{vii}

1.5 Much of the vision set out in the Long Term Plan cannot be delivered by the NHS alone. Improving outcomes in the health service also rests on looking beyond the NHS. The latest research shows that the economic and social cost of mental ill health in England has risen from £105bn in 2010 to £119bn in 2018/19.^{viii} Concerted effort in public mental health and prevention, investment in housing, increased resilience in social care and a benefits and

employment system that adequately takes account of mental ill health is vital to improve outcomes for the health system by tackling problems at an early stage to support them outside of the NHS or prevent them worsening to the point that acute clinical intervention is required. Local Authority public health services must receive urgent investment. Now is the time to invest in local services which are proven to reduce costs elsewhere in the system by preventing mental health problems and helping people to secure better life outcomes. A five-year settlement for public health services, growing at least at the same rate as the NHS is required. **We recommend an increase in the Public Health Grant budget at least in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24, as part of a multi-year settlement, which will ensure local authorities can continue to provide prevention and public health interventions. We suggest 4% should be ring-fenced annually for public mental health.**^{ix} This funding should be linked to the Joint Strategic Needs Assessments (JSNAs) for each locality and relevant local strategies. It should also align with the growth in the workforce of public mental health professionals and those working within voluntary, community and social enterprise organisations^x and to address the health inequalities in their local communities

1.6 Following the announcement of the abolition of Public Health England, there remains a need for national leadership, coordination of intelligence sharing on public mental health, working closely with Government departments and the NHS. This national leadership is particularly crucial as mental health is a less well-established part of the public health portfolio and historically only 1-2% of local public health budgets are dedicated to it (1.81% in 2019/20, or £60m).^{xi} In addition to specific public mental health work such as suicide prevention and mental health promotion/prevention and literacy, the national approach to public mental health should engage with both the broader determinants of mental health (poverty, housing, etc) as well as the wider health improvement initiatives, such as smoking cessation, substance misuse, and tackling obesity. Public Health England also played an important role in producing authoritative data and analysis on mental health and determinants – this should be retained and enhanced in any new arrangements.

Given that rates of depression have doubled since the onset of the pandemic and the potential savings to be made across Government and the NHS through investment in mental health prevention and promotion, the Government should increase funding for public mental health at a national level.

1.7 The COVID-19 pandemic has demonstrated the importance of a community asset-based approach and the need to promote healthy lifestyles and prevent poor mental and physical health at the earliest opportunity. Local authorities need the resources required to prepare for and respond to increasing levels of mental distress and co-morbid physical health problems in the population due to COVID-19 and as a result of lockdown, which has caused anxiety and loneliness, amongst other issues including alcohol and substance misuse. The CSR should commit to a real terms increase in the Public Health Grant^{xii} budget as part of a multi-year settlement, which will ensure local authorities can continue to:

- a. work towards **restoring total expenditure for adult substance use disorder services as a proportion of public health expenditure, aiming to get back to at least its 2013/14 levels of 29.9%, equating to a rise of £374m in current prices (based on 2018/19 figures),** and
- b. work towards **restoring total expenditure for specialist drug and alcohol use disorder services for children and young people back to at least its 2013/14 level (2.4% of public health expenditure), equating to a rise of £43m in current prices (based on 2018/19**

figures). This needs to be in line with the growth in addiction psychiatrists and the wider multidisciplinary team.

£30m of capital funding by 2024/25 should also be allocated to sustainably house drug and alcohol use disorder services.

1.8 Mental health supported housing is an essential foundation to reduce out of area placements, inpatient admissions and delayed discharges which routinely cost tens of thousands to the NHS and harm outcomes by keeping people on wards when they are medically well enough to be discharged simply because there is nowhere else for them to go. It is estimated that if current trends continue there will be a shortfall of nearly 47,000 supported housing places by 2024/25. According to the Crisp Commission, Mental Health Trusts reported that 39% of delayed discharges were caused by a lack of appropriate housing.^{xiii} Despite a government target to end acute out of area placements by 2020/21, there were 60,565 inappropriate acute out of area days in the first three months of the year. Other data shows that 63% of placements in mental health rehabilitation services are out of area.^{xiv} It is vital that investment is made to increase the supply of supported housing for people with a mental health condition to reduce pressure on inpatient capacity and improve value for money. Analysis of four accommodation services provided by Rethink Mental Illness suggests that since April 2019 these services have saved the NHS at least £750,000 in reduced inpatient costs.^{xv} Though every person's needs and recovery journey will be different, these represent a snapshot of the different types of accommodation someone severely affected by mental illness might need: short term crisis accommodation, low level supported housing, medium level supported housing and a CQC registered care home.

1.9 Funding to take forward reforms of disability benefits assessments including working with disabled people to design and test changes to the assessment process, increasing staff time and resource on decision-making and further funding to reform the Department for Work and Pensions' safeguarding processes. Where people are able to work but are unwell, Statutory Sick Pay (SSP) is a lifeline. The rate of SSP must be increased to match the National Living Wage and Minimum Wage to make sure people can meet their living costs at this time. The current rate of SSP - £95.85 per week - is far too low and research from Mind has shown that too often, it leaves people with mental health problems struggling to pay bills or buy food while off sick. **Having a rate of SSP which means people can afford to take time off when they're unwell can also help address the huge cost of poor mental health to employers. Annually, this has been estimated to cost between £33 billion and £42 billion, with over half of the cost coming from presenteeism, with additional costs from sickness absence and staff turnover.**^{xvi}

1.10 In response to the pandemic, the implementation of the CYPMH Green Paper programme and the roll-out of Mental Health Support Teams (MHSTs) must be accelerated. We cannot afford to leave desperate children and their families to struggle alone any longer. A counsellor in every secondary school in addition to the MHSTs is vital to ensure young people have access to the level of support that is appropriate to their needs in school. A qualified counsellor will enable those with needs higher than what can be met by a MHST practitioner to be get the help they need. These counsellors should be employed by the school on payroll to improve retention of staff and consistency of support for the young people seeking help. On the basis of 10% of all pupils in state secondaries require some mental health support, **£118m per annum should be allocated to provide school counselling to every child in secondary school who needs it.** This would deliver 2,623 FTE school counsellors, at a cost of £45,000 per counsellor per annum, to support a total of **341,000**

children every year. Accounting for inflation, this £118m p/a would rise to £130m after five years **at a total cost of £620m by the end of the five year period.**

However, some children and young people will continue to need support from specialist services. The government needs to increase the capacity of NHS CAMHS as well as adult mental health services, in order to ensure there are enough trained mental health professionals, day-care resources and in-patient beds as well as outreach and crisis teams to provide alternatives to hospitalisation. Any improvements to mental health support for children and young people will always heavily rely on having a robust mental health workforce, hence the importance of having a multi-year settlement for workforce training and education.

1.11 The Spending Review should invest in a national programme to expand access to evidence-based parenting interventions. This can build on learning from the Republic of Ireland, the US and Canada, where governments have invested in universal programmes which offer support for all with further help to those who need it. **England-wide coverage covering 152 local authorities would reach 1.9m families of 0-16 year olds at a cost of £60m over three years.** That is equivalent to £31 per family that engages with intervention. Targeting the 20 most deprived local authorities would reach 212,000 families of 0-16 year olds would cost at £8.2m over three years or £39 per family that engages with intervention.^{xvii}

1.12 Ultimately, difficulties with accessing appropriate support from social care, housing, employment or the welfare system can all exacerbate existing or contribute to the development of mental ill-health. Funding should be made available for voluntary and community organisations working in these areas to support a holistic approach. In June a group of 50 voluntary and social sector organisations wrote to the Prime Minister calling for a New Social Contract for a mentally healthy society. We believe this new approach should be centred on an ambitious Mental Health Renewal Taskforce and Plan, with mental health and wellbeing at the heart of the nation's overall approach to recovery from the pandemic. This must be backed by funding that meets the increased short and long term mental health need as a result of the pandemic, in the NHS, local authorities and the community sector. The CSR is a vital opportunity to establish a comprehensive cross-government approach to mental health at the highest level, with a Budget for Wellbeing across all government departments, similar to the approach being used in New Zealand. This is a robust measure of how government spending impacts on citizen wellbeing. **The principles of the New Zealand matrix for investment should be replicated in the UK by building on the existing data collected by the Office of National Statistics. A similar spend per capita in the UK would total £3.1bn.**

2. IMPROVING THE MANAGEMENT AND DELIVERY OF COMMITMENTS

2.1 We welcome the government's commitment to tackle the social care crisis. This must include provision for working age adults who use social care, as well as those of older people and carers and we have concerns that there has been a lack of focus on adults and their carers so far. Social care funding for people with mental illness and their carers could be the difference between living a fulfilling, independent life and a relapse leading to a hospital stay. Well-resourced social care is vital to ensure the successful delivery of Community Mental Health Framework (CMHF) – which sets out a transformative vision for treatment of people severely affected by mental illness - in the NHS Long Term Plan. Timescales for the roll out of the CMHF mean that this investment is needed now and should begin at the 2020 Budget. In the short term, immediate and sufficient funding must be provided to stabilise the social care system and ensure it does not collapse in the worst affected areas. Looking to the

medium term the Government must bring forward a plan to create a fair, effective and sustainable care system.

Social care reform must include provision for working age adults and an appropriate funding settlement that goes further than just a cap on care costs, as many people with SMI are unlikely to have the financial assets to meet that threshold. It also means ensuring that those in receipt of welfare benefits should not be asked to use these to pay for the social care support they receive so that they are not faced with the choice of increased financial difficulty or going without support. Social care reform must also include funding for associated support costs which are vital to the efficacy of mental health supported housing. Support funding is used to cover non-housing costs such as staff visits to help people live independently. The Supporting People Programme was introduced to cover these costs, but the ring-fence was removed in 2009. Between 2010/11 and 2016/17 spending fell by 69%^{xviii} and this cost now comes largely from social care budgets.

2.2 The pandemic has exposed and exacerbated the cracks that exist in the fragile social care system. Rethink Mental Illness recently surveyed people severely affected by mental illness and of the 194 people who answered our question on how the social care support they receive has changed since COVID-19, 45% said it had got worse or much worse. Good social care support and provision is also vital for adults and children with learning disabilities, and for the people who care for them to support them to live active and fulfilling lives in their communities, which is very important for protecting their mental health. We need to resource local authorities so that they can prepare for an increase in demand for mental health social care support, given the need to discharge patients safely into the community with a package of care in place and for the impact the pandemic is having on children and young people and their families.

2.3 The government cannot deliver on the commitments in NHS Long Term Plan without funding social care as an equal partner to the health service and cannot deliver on its commitment to resolve the acknowledge deficiencies in social care without ensuring adequate provision for adults and their carers. The social care budget for children, young people and adults should be increased to at least be in line with the funding uplift for NHS England of an average increase of 3.3% per year in real terms by 2023/24. We suggest that some of this should be ring-fenced funding devoted to early years, aiming to get it back to at least around 8% of the children's social care expenditure, equating to a rise of around £376m in current prices. There should also be modelling carried out to determine what dedicated, ring fenced funding would be necessary to adequately fund services people severely affected by mental illness and those that support them need such as community support, peer support, recovery services, advocacy and carers services.

2.4 While the government has committed to build more hospitals, mental health units must also be upgraded to ensure we have modern, world-leading NHS facilities for some of the most mentally vulnerable service users. The Care Quality Commission's (CQC) assessment is that many mental health wards are unsafe and provide poor quality care in old and unsuitable buildings. This means that many environments are not conducive to recovery of the most unwell people, and not an environment that contributes to staff morale and retention. In the wake of the pandemic we also must ensure that buildings enable clinicians to manage patients with COVID-19 while they are receiving treatment and support for their mental health, as well as preventing nosocomial transmission of the virus.

2.5 By 2024/25, there should be a ring-fenced investment of £3.34bn (in current prices) to NHS mental health trusts (in addition to their day-to-day capital budgets) to reconfigure existing estate through refurbishment, alterations and

extensions. When taking this proposed ring-fence investment of £3.34bn on top of mental health trusts' day-to-day capital budgets (based on trust budgets for day-to-day spending being at least maintained in current prices), the total investment over this period would equate to £4.4bn. Specifically, this proposed ring-fenced investment of £3.34bn could be funded from the recently announced capital injection for 2020/21 as well as the investment to be announced in the 2020 CSR (outlined below).

We welcome the £1.5bn that was brought forward for the NHS ahead of the CSR and the £250m of this that was committed to upgrade dormitory wards. We would like to see more of the remaining £1.25bn pot spent to address urgent issues in mental health. Of the £1.5bn nationally allocated capital funding for 2020/21, **DHSC and NHSE/I to allocate and ring-fence a total £375.9m (25.1%) to mental health NHS trusts to meet the following commitments during this financial year:**

- a. NHS critical maintenance and emergency/A&E capacity (£100.9m [9.6%] of £1.5bn total allocation)
 - £68m to enable NHS mental health trusts to urgently reconfigure their existing estate in response to the COVID-19 pandemic, including acquiring temporary facilities (if required). The NHSPS Taskforce should support mental health trusts leaders where necessary to procure and/or reorganise their estate as required
 - £12.9m to eradicate current high-risk maintenance backlog across mental health and learning disability sites/estates, and
 - £20m to begin to procure mental health ambulances/transport vehicles; create age-appropriate mental health assessment spaces in A&Es (or alternative) and acute hospitals; and begin to procure alternative forms of age-appropriate mental health crisis provision.
- b. Modernising the mental health estate (£250m total allocation)
 - £250m to begin to eliminate dormitory provision and replace with single en-suite rooms.
- c. Health Infrastructure Plan (£200m total allocation)
 - £25m of seed funding for the first five new major building and redevelopment schemes in mental health trusts. Decisions about which NHS trusts should be prioritised for seed funding for HIP projects should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads – potential trusts are detailed in the endnote.^{xix}

This investment should be taken as a down payment on plans to modernise the mental health estate for 2020/21 and beyond and to support delivery of the LTP and the recommendations of the Independent Review of the Mental Health Act, and should be on top of existing system-level allocations for 2020/21.

2.6 An additional ring-fenced investment of £2.96bn should be given to mental health NHS trusts between 2021/22 and 2024/25 as part of a multi-year capital settlement. This additional capital funding uplift should be in addition to trusts' day-to-day capital budgets and building on the momentum and previous targeted investment for 2020/21 as outlined above. This investment should include:

- a. a new Health Infrastructure Plan (HIP) for Mental Health – for longer-term assets that support the NHS' delivery of world-class mental healthcare and the accompanying healthcare infrastructure that supports mental health outcomes. Within this,

- £510m for the first instalment of a new £1bn building and redevelopment programme for mental health to enable six major building and redevelopment schemes to be awarded to mental health NHS trusts by 2024/25 (building on the proposed £25m of seed funding from 2020/21 and inclusive of a further £5m of seed funding for the sixth scheme), and with a commitment to deliver a further six mental health building and redevelopment schemes by 2030 (inclusive of a further £35m of seed funding). Decisions about which NHS trusts should be prioritised for seed funding should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads – potential trusts are detailed in the endnote^{xx}
 - £800m to improve the therapeutic environment of mental health and learning disability/autism inpatient settings by: eliminating mixed sex accommodation; procuring en-suite facilities for all existing single rooms; minimising the risks of harm through innovative safety improvement projects, and making the estate more suitable for people with disabilities
 - £350m to complete the elimination of dormitory provision and replace with single en-suite rooms. This should be on top of the £250m already committed in the recent funding announcement for the NHS, given estimates that it will cost £600m to completely eliminate dormitory provision.
 - £600m for new building and redevelopment schemes for community mental health facilities, including clinical and office space, in order to deliver the confirmed objectives of the LTP up to 2023/24 and the expected further expansion of services in the remaining period
 - £100m for new building and redevelopment schemes for crisis mental health facilities, including the procurement of mental health ambulances/ transport vehicles; creating age-appropriate mental health assessment spaces in A&Es (or alternative) and acute hospitals; and procuring age-appropriate alternative forms of mental health crisis provision – building on the proposed investment of £20m during 2020/21.
 - £30m of capital funding for drug and alcohol use disorder services^{xxi}
 - £250m to improve digital technology within mental health trusts, and
 - £160m for Research and Development in Mental Health and Dementia.
- b. £160.88m to eradicate current significant and moderate risk maintenance backlog in mental health and learning disability sites/estates.

DHSC must allow mental health trusts to spend their planned capital budgets in full each year given the historic underinvestment. This should enable trusts to address ongoing backlog maintenance issues, maintain safe services and minimise risks across their estate.

2.7 New Care Model Pilots, now known as Provider Collaboratives, for children and young people's specialist services have demonstrated that reducing reliance on acute beds – particularly those out of area – can result in significant financial savings. Independent evaluation from the Centre for Mental Health of the six Phase 1 and 2 sites showed that £15.3m of reduced expenditure was achieved by redesigning treatment and care for just 217 people; an average of £70.6k per person.^{xxii} The budgets agreed by NHS England to achieve this was £291m. An expanded programme which impacted on 1,000 people could save £70m

annually if sites can replicate the success of the Phase 1 and 2 teams. There is similar scope for savings to be made in adult and forensic services.

2.8 The Long Term Plan commitments cannot be realised without a sufficient workforce. The Long Term Plan requires 1,040 consultant psychiatrists by 2023/24, yet recent workforce forecasts from HEE indicate that only 71 additional consultant psychiatrists will be added to the mental health NHS workforce by that date if urgent action is not taken. Similarly, only 257 mental health nurses will be added to the NHS workforce by 2023/24 against a requirement of 7,000 needed to deliver the LTP. According to HEE, delays to the Spending Review and the impact of the COVID-19 pandemic on international recruitment are the main reasons behind this poor outlook. The CSR must set out resource to underpin a new, comprehensive, long-term NHS workforce strategy.^{xxiii} The government must commit to double the number of medical school places in England, at an estimated cumulative cost of £5.257bn by 2028/29 or £1.223bn per annum when fully implemented in current prices^{xxiv}, allocate those places to schools that have a clear plan to encourage more students to choose a shortage specialty, including psychiatry, which would equate to £420.54m of those total costs or £97.80m per annum when fully implemented in current prices if 8% of the total new places are taken by doctors choosing psychiatry.

It must also build on the current planned increases to the continuing professional development (CPD) budget for nurses (as announced at the Spending Round 2019) and work towards full restoration of up to £300m per year. A substantial proportion should be ring-fenced for mental health that is in line with the size of the mental health workforce, with an additional sum to reflect past disparity. Last but not least, the Government should commit to a multi-year settlement for workforce training and education to allow for the growth in the mental health workforce, including via new roles, necessary to deliver the LTP and the recommendations of the Independent Review of the Mental Health Act.

ⁱ Rethink Mental Illness (2020), COVID-19 briefings: Access to NHS mental health services for people living with severe mental illness. Available from: <https://www.rethink.org/media/3793/access-to-mh-services-final-040220.pdf>

ⁱⁱ Office of National Statistics (2020) Coronavirus and depression in adults, Great Britain: June 2020. <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/june2020>

ⁱⁱⁱ Bank J, Karjalainen H & Propper C (2020) IFS Briefing Note BN281 Recessions and health: The long-term health consequences of responses to coronavirus. London. Institute of Fiscal Studies

^{iv} Institute for Public Policy Research (2018) Mental Health: Putting Parity Into Practice. Available from: https://www.ippr.org/files/2018-10/1540372212_fair-funding-for-mental-health-october18.pdf

^v Department of Health and Social Care. Modernising the Mental Health Act. Final Report of the Independent Review of the Mental Health Act 1983. December 2018. Available from:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice_reducing_compulsion.pdf [Accessed 18 June 2020].

^{vi} Royal College of Psychiatrists. Royal College of Psychiatrists' briefing.

Analysis of second COVID-19 RCPsych member survey – other key themes. May 2020. Available from:

https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/second-rcpsych-covid-member-survey-summary---other-key-themes.pdf?sfvrsn=95c259cc_4 [Accessed 20 June 2020].

^{vii} Ibid.

^{viii} Centre for Mental Health (2020) A Spending Review for wellbeing.

https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMentalHealth_SpendingReviewForWellbeing.pdf

^{ix} The Public Health Grant can be used for both revenue and capital purposes -

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872798/DHSC_allocations_circular_2020_to_2021.pdf

^x Specifically, within this budget, local authorities to ring-fence at least 4% for public mental health spending, equating to a rise of 100%, or £70m, compared to 2018/19 figures, as the start of sustained and growing investment in this area.

^{xi} <https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2020-to-2021-budget-individual-local-authority-data>

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- ^{xii} The Public Health Grant can be used for both revenue and capital purposes - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872798/DHSC_allocations_circular_2020_to_2021.pdf
- ^{xiii} Crisp Commission, OLD PROBLEMS, NEW SOLUTIONS: Improving acute psychiatric care for adults in England, February 2016
- ^{xiv} CQC Briefing – Mental health rehabilitation inpatient services, March 2018
- ^{xv} Based on national level costs of mental health inpatient treatment, the actual costs of providing our services, and the referral information for the people who use them.
- ^{xvi} Stevenson, D. Farmer, P. (2016) [Thriving at work: The Stevenson / Farmer review of mental health and employers](#)
- ^{xvii} Centre for Mental Health (2020) A Spending Review for wellbeing. https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMentalHealth_SpendingReviewForWellbeing.pdf
- ^{xviii} National Audit Office, Financial sustainability of local authorities 2018, August 2018
- ^{xix} Decisions about which mental health trusts should be prioritised for seed funding for HIP projects should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads. Without wishing to presume the outcomes of those discussions, we have identified some trusts that might benefit from capital transformation funding in particular given the age of their estate or a poor CQC safety rating. These trusts include:
- Inadequate for Safety* (acute wards: working age adults and psychiatric intensive care)
1. Bradford District Care NHS Foundation Trust
 2. Lancashire and South Cumbria NHS Foundation Trust
 3. Leicestershire Partnership NHS Trust
 4. Nottinghamshire Healthcare NHS Foundation Trust
 5. Sheffield Health and Social Care NHS Foundation Trust
- Ageing estate* (NB - As of most recent data in 2015, in order of highest proportion of estate built before 1948)
6. South West London and St George's Mental Health NHS Trust
 7. South London and Maudsley NHS Foundation Trust
 8. West London NHS Trust
 9. Surrey and Borders Partnership NHS Foundation Trust
 10. Devon Partnership NHS Trust
 11. Oxford Health NHS Foundation Trust
 12. Kent and Medway NHS and Social Care Partnership Trust
- ^{xx} Ibid.
- ^{xxi} This is on top of the Public Health Grant funding to expand drug and alcohol use disorder services.
- ^{xxii} O'Shea, N. (2020) Bringing care back home: evaluating the New Care Models for children and young people's mental health. Centre for Mental Health and NHS Confederation Mental Health Network. https://www.centreformentalhealth.org.uk/sites/default/files/2020-03/CentreforMH_BringingCareBackHome_0.pdf
- ^{xxiii} NHS England & Improvement. Online version of the People Plan for 2020/2021. 30 July 2020. Available from: <https://www.england.nhs.uk/ourhsp/online-version/> [Accessed 5 August 2020].
- ^{xxiv} The estimates for the cost of a doubling of medical school places in England is based on the following assumptions: 2017 costings for training a doctor, which were around £163,000 after accounting for student loans being repaid; and the proposed expansion in places is 750 new places for 2021/22 and 2022/23 followed by six years of 1,000 additional places to 2028/29 inclusive.