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REPORT

Progress in improving mental health services in England

Department of Health & Social Care

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Progress in improving mental health services in England

Department of Health & Social Care

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

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Key facts

4.5mn

number of people in contact with NHS-funded mental health services during 2021-22

£12.0bn

NHS spend on mental health services in 2021-22, equivalent to around 9% of the NHS budget

4.9 times

people with severe mental illness more likely to die prematurely than the general population during 2018–2020

22% (24,000)	increase in NHS mental health workforce between 2016-17 and 2021-22
44%	increase in referrals to NHS mental health services between 2016-17 and 2021-22, from 4.4 million in 2016-17 to 6.4 million in 2021-22
8 million	NHS England estimate of the number of people with mental health needs not in contact with NHS mental health services, as of 2021
1.2 million	estimated number of people on the waiting list for community-based NHS mental health services at the end of June 2022
26%	estimated proportion of 17- to 19-year-olds with a probable mental disorder in 2022, increasing from 10% in 2017
17%	proportion of NHS mental health funding spent on non-NHS providers, including independent and voluntary sector providers, in 2021-22
61%	for July to September 2022, proportion of referrals to talking therapy services excluded from calculation of waiting time standards

Summary

Introduction

1 Many people will experience mental health problems in their lives. Around one in six adults in England have a common mental health disorder, and around half of mental health problems start by the age of 14. The proportion of young people estimated to have a probable mental disorder rose between 2017 and 2022, following the COVID-19 pandemic: for example, among 17- to 19-year-olds, the proportion went up from 10% to 26%.

2 In 2011, the government set out long-term ambitions to improve support and services for people with mental health problems and achieve 'parity of esteem' with physical health services. These seek to reduce the personal, social and economic costs of mental health problems, by addressing the causes of such problems, and identifying and treating them earlier. The government acknowledged a large 'treatment gap' for people with mental health conditions and, from 2016, the Department of Health & Social Care (DHSC) and NHS England (NHSE) made specific commitments to improve and expand NHS-funded mental health services. NHSE, working with DHSC and other national health bodies, set up and led a national improvement programme to deliver these commitments.

3 In 2021-22, the NHS spent around £12.0 billion on mental health services. The NHS directly provides a wide range of mental health services in England, as well as commissioning services from non-NHS providers. Different services cover specific conditions, treatment approaches, specific groups (for example, children and young people), and community and inpatient settings. Most mental health services are commissioned locally by integrated care boards (ICBs), which replaced clinical commissioning groups (CCGs) in 2022. As for all NHS services, DHSC, NHSE and other arm's-length bodies provide oversight, assurance and support for mental health services.

Scope of the report

4 This report focuses on the implementation of NHS commitments as set out in the *Five Year Forward View for Mental Health* (FYFV, July 2016); *Stepping forward to 2020/21: The mental health workforce plan for England* (Stepping Forward, July 2017); and *The NHS Long Term Plan* (LTP, January 2019).

5 We examined whether the government has achieved value for money in its efforts to date to expand and improve NHS-funded mental health services by evaluating whether DHSC, NHSE and other national bodies:

- have a clear understanding of how much their work to date has reduced the gap between mental and physical health services (Part One);
- met ambitions to increase access, capacity, workforce and funding for mental health services (Part Two and Part Three); and
- are well placed to overcome the risks and challenges, including the impact from COVID-19, to achieving future ambitions (Part Three).

6 The national improvement programme is very broad, so this report focuses on its ambitions to:

- improve access to services, and the timeliness and quality of services that people receive, supported by the introduction of new targets and standards for access and waiting times in specific service areas;
- provide more integrated, people-centred services in community mental health services, an area to which the new access and waiting time standards largely did not apply;
- increase the mental health workforce;
- increase the relative share of funding for mental health services; and
- improve the available data and information on mental health services.

While this report does not evaluate preventive mental health services, it includes some commentary on the role of prevention. It does not cover NHS services for people with learning disabilities, autism or dementia, or for substance abuse.

Key findings

Improving services for patients

7 Introducing access and waiting time standards for mental health services was an important step towards parity of esteem with physical health services. The NHS has used such measures to manage physical health services since 1991 but only introduced them for some mental health services from 2015. Most trusts, ICBs and other stakeholders in our surveys and interviews agreed that the new access and waiting time standards had helped to improve these services, by increasing transparency and providing a focus for attention. However, unlike the standards for physical health services, the standards for mental health only cover a limited number of service areas, and do not apply to the bulk of core community and inpatient mental health services. In 2021-22, NHSE started publishing a national estimate of the number of people waiting for community-based mental health services. By contrast, published waiting time data for physical health services are more comprehensive, detailed and linked to defined service standards (paragraphs 1.9, 2.4, 2.5 and 2.8).

8 Overall, the number of people treated by NHS mental health services has increased, but some access targets are not being met. Between 2016-17 and 2021-22, the number of people in contact with NHS mental health services increased from 3.6 million to 4.5 million. NHSE also speeded up the rollout of 24/7 crisis services ahead of targets during the pandemic. While overall service activity has increased, the NHS has missed targets for specific service areas. For children and young people's services, NHSE reported that before the pandemic the NHS was on track to treat the higher numbers of people it planned to, but for 2021-22 it was 3% below target for 0- to 17-year-olds. For talking therapy services, the number of people accessing the service was below target before the pandemic, while in 2021-22, 1.2 million people accessed the service, 22% below the target of 1.6 million (paragraphs 2.2 to 2.4).

9 The NHS has achieved its waiting times standards, which aim to get people into treatment quickly, for talking therapy services and early intervention in psychosis services, but not yet for eating disorders services for children and young people. From 2015, NHSE introduced waiting times standards for these three service areas, and made good progress against them up to 2019-20. The NHS has met the standards for talking therapy services and early intervention in psychosis services both before and after the pandemic. For eating disorder services for children and young people, the NHS has not yet met the standard it aimed to achieve from 2020-21 and, following surges in the number of children and young people with eating disorders, waiting times increased further during the pandemic. During April–June 2022, 68% of children and young people who were urgently referred to eating disorder services were seen within a week, against a standard of 95%. The main measures of waiting time performance are useful headline indicators, but may not fully reflect people's experiences, for example, by excluding people who drop out before or during treatment (paragraphs 2.5 to 2.7).

10 NHS mental health services are under continued and increasing pressure and many people using services are reporting poor experiences. The Care Quality Commission has raised concerns about the 'gridlocked' health and care system, and particularly about children and young people's mental health services. A range of measures show pressures on services. For example, the number of mental health patients placed inappropriately in hospitals outside their local area, which can indicate a shortage of local capacity, has averaged above 600 per month since April 2021, despite a long-standing ambition to eliminate this practice. In our survey of NHS mental health trusts, most reported that in response to demand and service pressures, they had allowed waiting times and lists to increase, while a minority had raised treatment thresholds (15 out of 33) and reduced provision in some service areas (six out of 33). Our interviews with stakeholders highlighted that some groups had poorer experiences accessing or using services, including children and young people, people from minority ethnic groups, LGBT people, and people with more complex needs or more than one diagnosis (paragraphs 2.10, 2.11, 2.18 and 2.19).

11 NHS England's ambitious plan for community-based mental health services is still at an early stage. NHSE aims to provide more integrated services for people with mental health needs in the community. This involves new care models, with better coordination between the range of different NHS mental and physical health services, and other services (for example, social care) that an individual may need. NHSE is providing an additional £1 billion by 2023-24 to support this. By September 2022, NHSE reported that 34% of primary care networks had fully or partially implemented these new care models. Although NHSE tracks progress on improving access to services, it has not established indicators that would allow it to understand the full benefit of its plans, for example, on timeliness and quality of care, and patient outcomes. The introduction of integrated care systems (ICSs), which bring together local NHS commissioners and providers with local government, offers opportunities to improve local provision but many ICBs are concerned that they do not have the required resources and capacity. The NHS will have to overcome other challenges to such a large and complex change in services, including financial and workforce constraints for local authorities and GPs, where little capacity and activity information is available (paragraphs 1.9 and 2.12 to 2.17).

12 The impact of initiatives to reduce inequalities in mental health is not yet clear. NHSE has taken actions to improve data on variations in patients' access, experiences and outcomes and to reduce known inequalities, including setting up a dedicated taskforce, providing funding and setting expectations for ICBs to reduce the level of local inequalities. In our survey of ICBs, only two of 29 said they had all or most of the data needed to assess variations in patients' access, experiences and outcomes. More data on variations in access are now routinely available nationally but data gaps remain. It is not yet clear what impact NHSE's initiatives have had on reducing inequalities in patients' experiences and outcomes (paragraphs 2.22 to 2.26).

Increasing mental health service workforce, funding and information

13 Although the NHS mental health workforce has increased, staff shortages remain the major constraint to improving and expanding services. Between 2016-17 and 2021-22, the NHS mental health workforce increased by 22%, to 133,000 full-time equivalent staff. This varied by staff group: for example, nursing numbers grew by less than NHSE and Health Education England (HEE) initially estimated (9% actual against 16% initially estimated), while the number of people in therapist roles increased by more than the initial estimate (41% against 25%). Our survey of NHS mental health trusts highlighted particular concerns about shortages of medical and nursing staff, and psychologists, and a wide range of reasons for shortages. These include problems recruiting and retaining staff, a high turnover of staff between service areas, and competition from health and non-health sectors. As of 2022, the NHS still lacked a long-term workforce strategy, and had not met a commitment to publish a five-year plan in 2019, although an NHS workforce plan is now expected in 2023. The lack of a strategy makes it harder for national and local bodies to coordinate efforts to train and recruit staff, particularly when levers for workforce growth are spread across different bodies, and funding for workforce education and training tends to be short-term and not always aligned with projected staff requirements. Retaining staff is also becoming an increasing challenge: during 2021-22, 17,000 staff (12%) left the NHS mental health workforce, up from 13,000 (9%) a year earlier. The NHS must also carefully manage the shift in the workforce to more junior and non-clinical roles, given the reported increase in the complexity of patients' needs (paragraphs 3.2 to 3.6 and Figure 12).

14 The share of funding for mental health services has increased slowly, reflecting the pace set by NHSE's targets. Since 2015-16, CCGs have met commitments to increase their spending on mental health services faster than their overall allocations and, since 2019, to increase their spend on children and young people's services faster than overall spend on mental health services. While NHSE has improved its monitoring of local spend, the rate of change remains slow. We calculated that the proportion of CCG funding spent on mental health services (excluding spending on learning disability, autism and dementia) increased from 11.0% in 2016-17 to 11.4% in 2020-21. Our analysis suggests that NHSE was on track to meet commitments to increase annual mental health spending by £3.4 billion in cash terms by 2023-24, compared with 2018-19. Although a robust baseline measure was not available, our analysis also suggests that NHSE had achieved its commitment to spend an additional £1.3 billion on transforming children and young people's mental health services for the period 2016-17 to 2020-21. We identified funding and commissioning issues that national and local bodies will need to address, including the lack of information on actual costs of services provided, which makes it difficult to quantify any historical under-funding, and the use of overly complex and fragmented commissioning arrangements (paragraphs 3.7 to 3.12).

15 Improvements to mental health data and information are taking longer than planned in many areas. NHS Digital, NHSE and the Office for Health Improvement and Disparities now regularly publish information on service activity and performance against access and waiting times standards, local spending on mental health services, and information on mental health inequalities. However, plans to improve data that are important for developing services and measuring improvements, for example, on access to services, are taking longer than expected. For example, all providers should have been submitting data for NHS Digital's core Mental Health Service Data Set by 2020-21. While the number of providers submitting data has increased from 85 in 2016 to 364 in 2022, 5% of NHS providers and up to 33% of non-NHS providers were still not yet doing this by June 2022. Routine information on outcomes is now available for talking therapy services, but outcome measures for other service areas are at a much earlier point in development (paragraphs 2.20, 2.24 to 2.26 and 3.13 to 3.16).

Achieving parity of esteem

16 DHSC and NHSE have not defined what achieving full parity of esteem between mental and physical health services would mean. In our view, this should include the estimated proportion of people in need that different mental health services should ultimately cover, the desired staffing profile, and the share of funding between mental and physical health services. Without a definition and associated measures, it is not possible to say how far the current improvement programme takes the NHS towards full parity of esteem (paragraph 1.15).

17 Plans for service expansion up to 2023-24 still leave a sizeable gap between the number of people with mental health conditions and how many people the NHS can treat. NHSE has stated that, even under a full parity of esteem scenario, it would not expect 100% of all people with mental health needs to need NHS treatment. However, the planned rates of service expansion under the current programme mean that, by 2023-24, there will still be sizeable treatment gaps. For example, we estimated that the 2023-24 ambition for 1.9 million people to access talking therapy services equated to around one quarter of people with a diagnosed need. The main constraint on service expansion is how fast the workforce can increase: for example, training for new psychiatrists takes at least 12 years. Previous government strategies have also emphasised the importance of improving preventive (non-NHS) services alongside treatment services, but we heard strong concerns from stakeholders about a continued lack of funding for such services (paragraphs 1.15 to 1.20).

18 The national programme, led by NHSE, has maintained a consistent focus on expanding services. The programme has overseen delivery of a series of commitments made to improve and expand services. Our review of the programme identified some strengths, including strong national leadership, a consistent focus and objectives for service expansion, clear lines of accountability, and its approach to sharing lessons, stakeholder engagement and understanding and monitoring progress. However, the programme had not been able to fully address major risks to achieving its aims, including addressing workforce shortages and making planned progress on improving data. There were also limitations in the extent to which it could assess relative value for money and returns on investment. The 2023 reorganisation of national health bodies, following the introduction of ICBs in 2022, means NHSE has to proactively ensure that mental health continues to get sufficient attention as oversight and accountability arrangements develop (paragraphs 1.5, 1.8 to 1.13, 3.2 to 3.6, 3.15 and 3.16).

19 Increased demand and disruption following the pandemic mean it is likely to take longer for the NHS to close treatment gaps. Demand for mental health services is likely to be higher than the 2019 NHS LTP anticipated, including as a result of the pandemic and particularly among young people. For example, in 2022, the proportion of young people with probable mental disorders increased by 50% for 7- to 16-year-olds (from 12% in 2017 to 18% in 2022) and more than doubled for 17- to 19-year-olds (from 10% to 26%). Any increases in prevalence mean that it will take longer to reduce the gap between demand for mental health services and provision, or the gap could increase. NHSE has now announced delays of at least a year to achieving some of the original LTP ambitions for 2023-24, with a reduced set of six national objectives for mental health. It has also consulted on new waiting time standards for community mental health, and accident and emergency (A&E) mental health services, which would represent a major extension of the standards, but has not confirmed whether these will be implemented (paragraphs 1.12, 1.13, 3.17 and 3.18).

Conclusion on value for money

20 Since 2016, the NHS has taken some important first steps towards closing the historical and acknowledged gap between mental and physical health services. DHSC and NHSE made a series of clear commitments and plans to expand and improve mental health services, but they have not defined what achieving full parity of esteem for mental health services would entail. Consequently, it is unclear how far the current commitments take the NHS towards its end goal, and what else is needed to achieve it. While funding and the workforce for mental health services have increased and more people have been treated, many people still cannot access services or have lengthy waits for treatment. Staff shortages continue and data that would demonstrate the results of service developments are limited.

21 DHSC and NHSE acknowledge that it will now take longer to achieve some of the existing commitments following the COVID-19 pandemic, amid signs of a large rise in mental health conditions, particularly among young people. Over the next few years, demand for mental health services will continue to significantly outstrip provision, putting pressures on patients, staff and people trying to access services. DHSC and NHSE have plans to pursue challenging new ambitions such as improving community mental health services, but they need to be in a position to apply the lessons learned from their efforts to date. They have further to go to ensure value for money in their expansion efforts and will need to demonstrate a firmer grip on the significant ongoing risks to their ambitions.

Recommendations

22 Improving NHS mental health services is an important component of the government's ambitions to achieve broader parity of esteem for mental health and wellbeing. We make the following recommendations to ensure further progress towards this.

a DHSC and NHSE should publish a detailed statement of what achieving full 'parity of esteem' between mental and physical health services encompasses, in terms of access and service standards, staffing model and funding allocations, and the road map for national bodies, ICBs and local providers to achieve it.

b Either separately or as a distinct part of the overall NHS workforce plan due in 2023, DHSC and NHSE should publish a longer-term mental health workforce recruitment and retention strategy and a costed plan, that reflects the volume and skills required to meet future service ambitions. They will need to engage closely with HM Treasury in this process. The strategy should include how they will work with ICBs on local workforce development, recruitment and retention.

c NHSE, working with local ICBs and providers, should improve its data and analysis to better understand the relative cost and cost-effectiveness of different services, and provide a more robust basis to decide future priorities.

d NHSE, working with ICBs, should develop and issue guidance in 2023 on how the system will gain more transparency over capacity, activity, performance and outcomes in community mental health services, including improvements required to implement the proposed new clinical standards, as well as mental-health- related capacity and activity in primary care.

e As mental health services will need to remain the focus of sustained improvement and in the light of the national and local reorganisation of health bodies, DHSC and NHSE should set out the future approach to leading, monitoring and assuring oversight of mental health service expansion and improvement. This should include how they ensure that ICBs and NHS providers have sustainable plans for workforce and service models in the short to medium term.

Part One

Introduction and background

1.1 Part One sets out:

- the government's long-term ambitions to improve support for mental health and wellbeing in England, across NHS, local and other services;
- the provision of NHS-funded mental health treatment services in England;[1]
- the national NHS improvement programme, which aims to implement specific commitments to expand and improve NHS mental health services, and which is the main focus of this study; and
- progress towards achieving the longer-term goal of 'parity of esteem' between mental and physical health services.

1.2 The National Audit Office (NAO) has looked at progress against the government's ambitions for NHS mental health services twice before. In 2016, we examined early preparations for introducing new access and waiting time standards, and in 2018, we examined progress against ambitions to improve mental health services for children and young people.[2]

Government ambitions to improve mental health and wellbeing support

1.3 Around one in six adults in England have a common mental health disorder.[3] Around half of mental health disorders (excluding dementia) start by the age of 14. In 2017, the proportion of young people with a probable mental disorder was estimated at around 12% for 7- to 16-year-olds and 10% for 17- to 19-year-olds, but by 2022, following the COVID-19 pandemic, this rose to 18% and 26% respectively. People with mental health conditions often have poorer physical health, education and housing. Mental health conditions also affect people's ability to work: estimates from 2017 indicated that poor mental health at work cost the UK economy an estimated £74 billion to £99 billion per year.

1 In this report, 'NHS-funded' or 'NHS' mental health services comprise treatment services provided by NHS trusts or GPs, and NHS-funded services provided by local authorities, schools, independent, voluntary or charitable sector providers.

2 Comptroller and Auditor General, *Mental health services: preparations for improving access,* Session 2015-2016, HC 492, National Audit Office, April 2016.
Comptroller and Auditor General, *Improving children and young people's mental health services,* Session 2017-2019, HC 1618, National Audit Office, October 2018.

3 Common mental health disorders include conditions such as depression, anxiety disorders, phobias and obsessive-compulsive disorder.

1.4 The government's initial mental health strategy in 2011 sought to "mainstream mental health and establish parity of esteem between services for people with mental and physical health problems" (**Figure 1**). In 2014, its vision of 'parity of esteem' covered timely, accessible and appropriate support and services across NHS, local and other services. Taken together, these strategies recognised the high personal, social and economic cost of mental health problems, and the potential for avoiding many of these costs by addressing the causes of such problems and identifying and treating them earlier.

1.5 Alongside more investment in mental health promotion and prevention, the government acknowledged the need to improve healthcare, and reduce the large 'treatment gap' for people with mental health conditions. From 2016, it set out specific commitments and targets to improve and expand NHS mental health services, principally in the *Five Year Forward View for Mental Health* (FYFV) and *The NHS Long Term Plan* (LTP). In 2016, NHS England (NHSE)[4], working with the Department of Health & Social Care (DHSC) and other national health bodies, established a national programme to oversee delivery of these commitments.

Provision of NHS-funded mental health services in England

1.6 As for all NHS health services, DHSC, NHSE and other national health arm's-length bodies provide funding, oversight and support for local areas and providers of mental health services. These relationships and responsibilities are set out in **Figure 2** on pages 16 and 17. In 2021-22, the NHS spent around £12.0 billion on mental health services in England, around 9% of the total NHS budget.[5] Most mental health services (£9.7 billion in 2021-22) are commissioned locally by integrated care boards (ICBs), which replaced clinical commissioning groups (CCGs) from 2022 (**Figure 3** on pages 18 and 19).

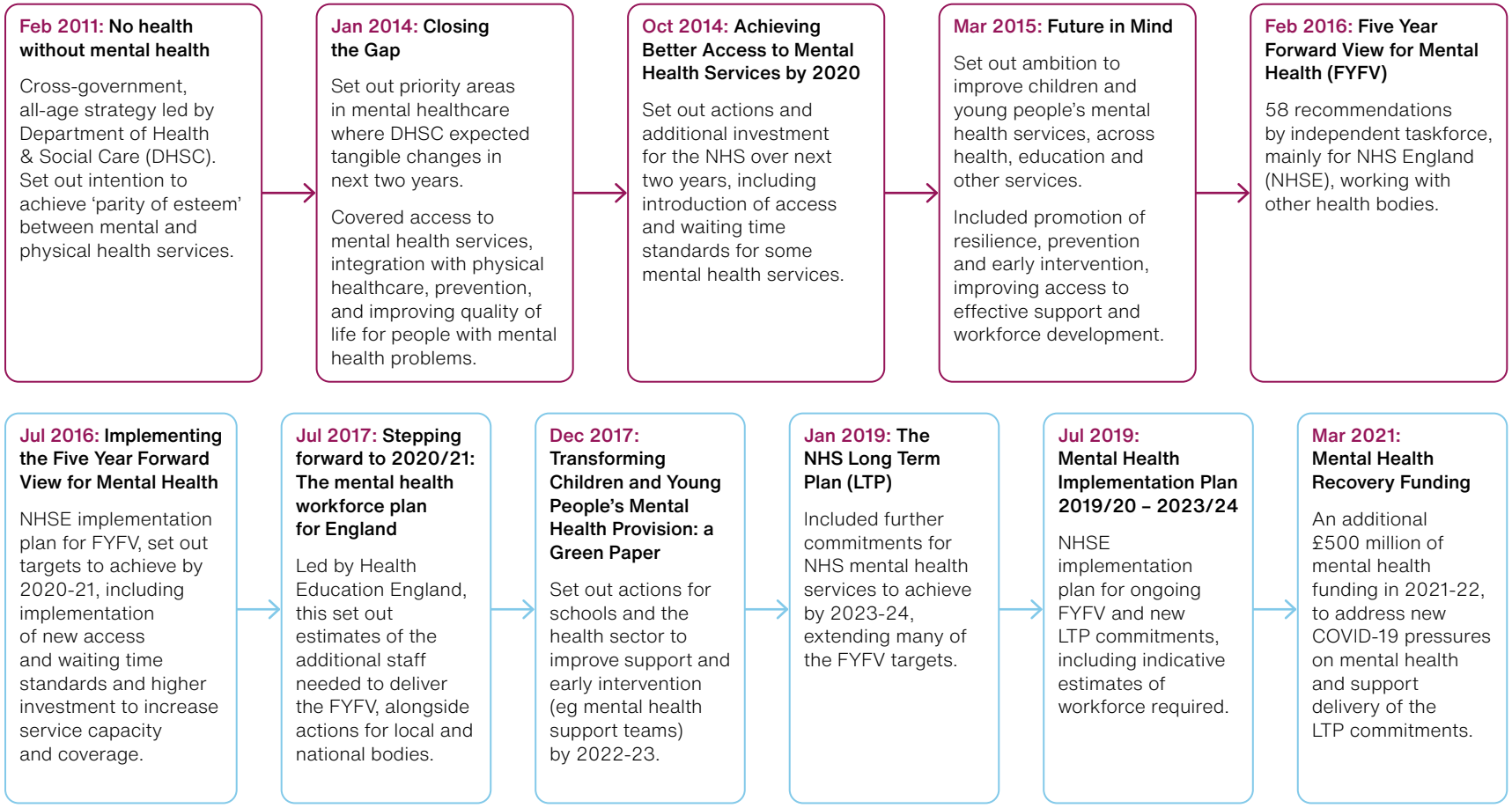
4 NHS England and NHS Improvement were merged on 1 July 2022 to become a single organisation called NHS England. For simplicity, this report refers to NHS England throughout.

5 Our study does not cover specific learning disability and autism, and dementia services, although it would include mental health treatment provided to such groups. Where possible, these services have been excluded from analysis of activity, spend and performance. We state where this is not possible or appropriate. Our analysis of non-NHS spend in NHS trust and CCG accounts includes spend on learning disability and autism services.

Figure 1

Main strategies and initiatives to improve mental health services in England, 2011–2021

From 2016, the government set out specific commitments and targets to improve and expand NHS mental health services



Notes

1 Not all published strategies shown.

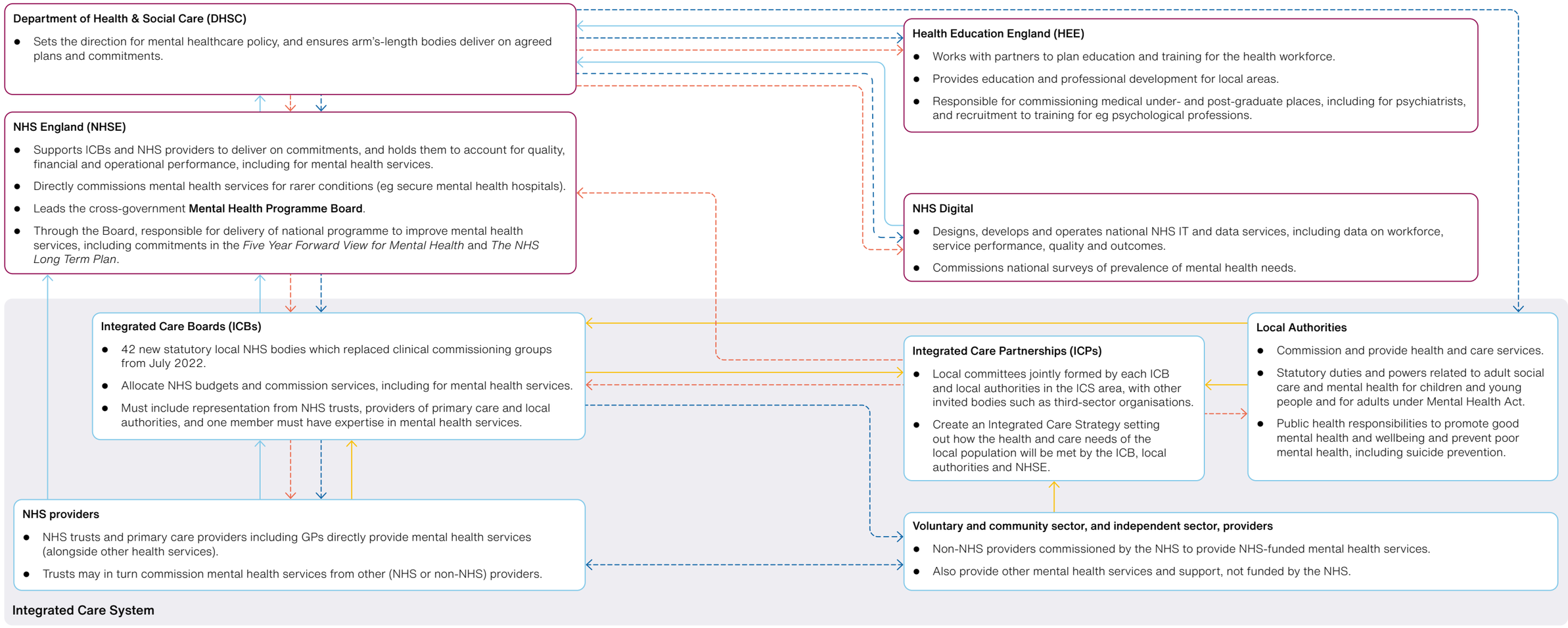
2 The cross-body NHSE-led Mental Health Programme Board oversaw delivery of the FYFV, LTP and Stepping Forward commitments. A separate DHSC-led board oversaw the Mental Health Recovery Funding.

Source: National Audit Office summary of published government documentation

Figure 2

Responsibilities for oversight and provision of mental health services in England

NHS-funded mental health services are provided by a combination of NHS trusts, GPs and non-NHS providers, with most commissioned locally by integrated care boards



Note

1 NHS England and NHS Digital formally merged on 1 February 2023, with Health Education England also due to merge with NHS England from 1 April 2023.

Source: National Audit Office analysis of published Department of Health & Social Care, NHS England, NHS Digital and Health Education England documentation

Figure 3
Spend on NHS mental health services in England by type of service, 2021-22

NHS England spent a total of £12 billion on NHS mental health services in 2021-22 including core services in the community and services for children and young people

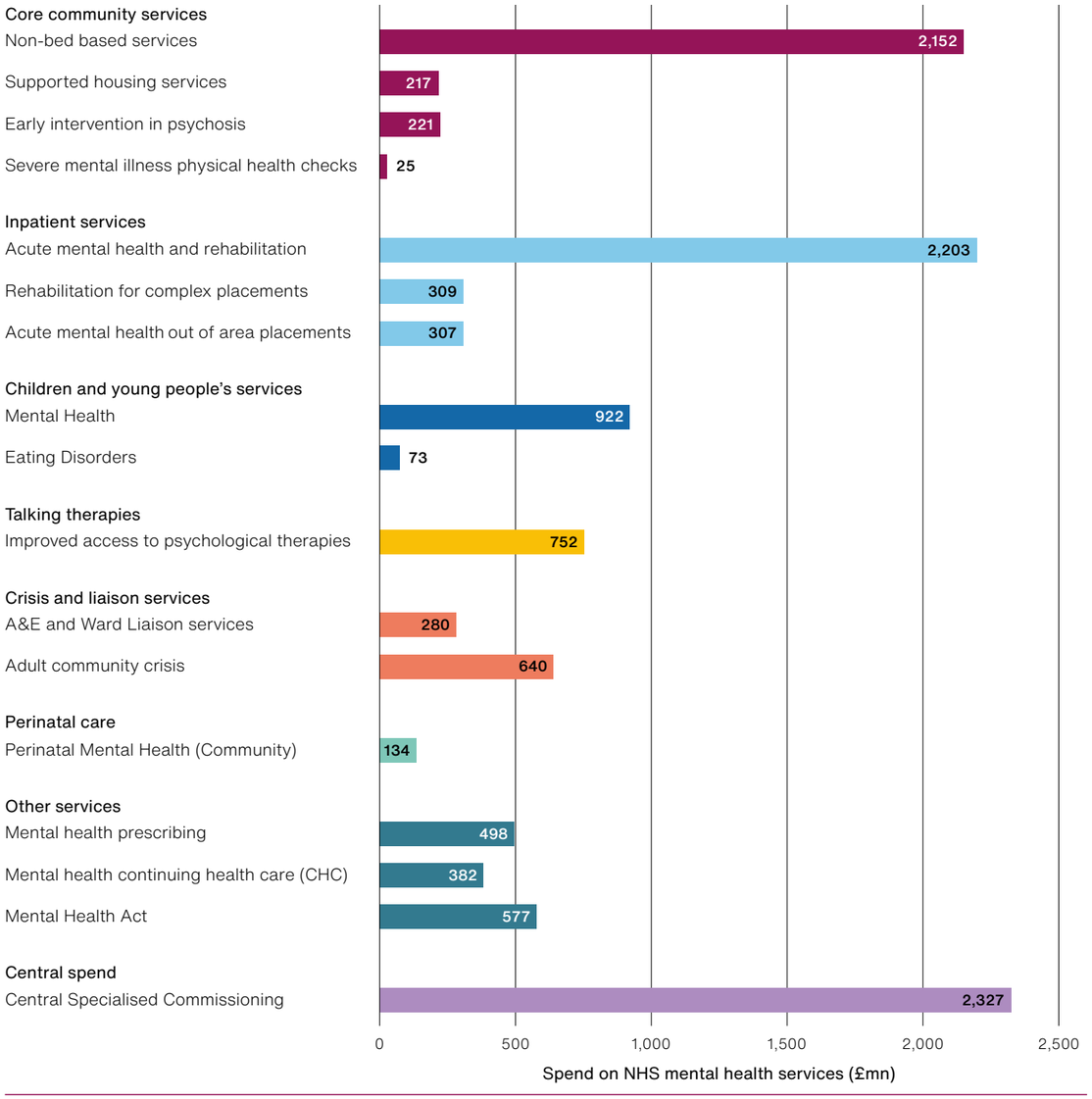


Figure 3 *continued*
Spend on NHS mental health services in England by type of service, 2021-22

- **Core community mental health services** for adults, including for people with severe mental illness (SMI), such as early intervention in psychosis services.
- **Inpatient services**, including therapeutic acute inpatient care.
- **Children and young people's mental health services** for those aged 0–18 (in some areas, 0–25), including treatments for common mental illness and eating disorders, and crisis services.
- Improving Access to Psychological Therapies (IAPT), or **talking therapy** services, for common mental health problems such as anxiety or depression.
- **Crisis and liaison services** for those in a mental health crisis or emergency, including community-based teams, and A&E-based liaison psychiatry services.
- **Perinatal mental health services**, for new or expectant mothers.
- **Other mental health services**, for example, for rough sleepers, or forensic services for people who have committed, or are at risk of committing, serious offences.
- **Specialised commissioning** by NHS England for less common services, such as secure mental health hospitals.

Note

1 The analysis includes NHS England spend on specialised commissioning and local clinical commissioning group (CCG) spend on mental health services, as reported to NHS England for the Mental Health Investment Standard. The CCG spend excludes spending on learning disabilities, autism and dementia services, as well as any (non-recurrent) transformation funding used for mental health services.

Source: National Audit Office analysis of NHS England data

1.7 The NHS provides a range of different mental health treatment services in England, which may have different commissioning arrangements depending on the service type, provider and locality (Figure 2 and Figure 3).

- Most mental health services are provided by NHS trusts or GPs. The NHS also commissions and funds services from independent, voluntary, charitable or local authority providers. Our analysis of CCG and NHS trust accounts estimated that around 17% of their spend on mental health services went to non-NHS providers in 2021-22.
- There are separate services for adults, and children and young people. In 2021-22, services for children and young people made up 8% (£995 million) of mental health service spend.
- A range of therapeutic services are aimed at different conditions, for example, Improving Access to Psychological Therapies (IAPT) commonly known as talking therapy services, for common mental health disorders.[6]
- Services can be located in community, primary care, inpatient and A&E settings, or accessed through helplines or online. Community services account for the majority of activity, with £2.6 billion of spend in 2021-22.

6 Psychiatrists and GPs also prescribe medications for mental health issues. CCGs spent £498 million on mental health prescribing in 2021-22.

The national programme to improve and expand NHS mental health services

Current structure and priorities

1.8 From 2013, the NHS had an explicit commitment to achieving parity of esteem between its mental and physical health services. In 2016, NHSE set up a national improvement programme under the Mental Health Programme Board, to oversee delivery of the specific commitments it had made to improve and expand NHS mental health services.[7] NHSE leads the Board, which also includes DHSC, Health Education England (HEE), NHS Digital and other national health bodies, local area and provider representatives, and external advisory experts.[8] The programme has a broad scope, with more than 90 active deliverables as at May 2022.

1.9 As noted in our 2016 report, the introduction of access and waiting times standards to mental health services, which are common in physical health services, was an important first step to achieving parity of esteem between the services. This study focuses on progress with that initiative, together with four other areas that we identified as the main challenges for DHSC and NHSE to address (**Figure 4** on pages 21 and 22), which cover the programme's aims to:

- improve access to services (the number of people treated), and the timeliness and quality of services that people receive, supported by the rollout of the new standards to specified service areas;
- from 2018, provide more integrated, people-centred services in community mental health services, an area to which the new access and waiting time standards largely did not apply;
- increase the mental health workforce;
- increase the relative share of funding for mental health services; and
- improve the available data and information on mental health services.

We look in detail at progress against these in Part Two (service performance) and Part Three (workforce, funding and data).

7 These were principally the commitments set out in: Independent Mental Health Taskforce to the NHS in England, *Five Year Forward View for Mental Health*, February 2016; Health Education England, *Stepping forward to 2020/21: The mental health workforce plan for England*, July 2017; and NHS, *The NHS Long Term Plan*, January 2019.

Additional commitments on children and young people's services were set out in: NHS England, *Future in mind*, March 2015; Department of Health & Social Care and Department of Education: *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps*, July 2018.

8 For 2021-22, DHSC led a separate Mental Health Recovery Oversight Group to oversee £500 million of post-pandemic funding. Treasury conditions of funding required separate oversight, but to reduce duplication, reporting and assurance processes were coordinated with the Mental Health Programme Board.

Figure 4

Overview of main milestones for mental health service improvement, in relation to access and waiting time standards, improving community mental health services, workforce, funding and data

The national NHS England mental health improvement programme has a broad scope

Selected main milestones	Detail of main milestones	Type of milestone
Access and waiting time standards		
Following *The NHS Long Term Plan* (LTP) in 2019, NHS England had an overall ambition for an additional 2 million people to access NHS-funded mental health services by 2023-24.		
It established specific access targets across a range of service areas, alongside waiting time and quality standards for specific areas.		
Early intervention in psychosis	By 2020-21 (and thereafter), 60% of people experiencing a first episode of psychosis to have access to a NICE-approved care package within two weeks of referral.	Access/quality
	By 2023-24, 95% of services to achieve Level 3 NICE concordance. Interim target for 2021-22 was 70% concordance.	
Talking therapies, or IAPT services	By 2023-24, a total of 1.9 million adults and older adults per year to access NICE-approved IAPT services. Interim target for 2021-22 was 1.6 million.	Access
	By 2020-21 (and thereafter), 75% of people to access IAPT treatment within six weeks and 95% within 18 weeks; and at least 50% achieve recovery across the adult age group.	Waiting times/ outcomes
Children and young people's services	By 2020-21, 70,000 additional children and young people (aged 0–17) each year to receive evidence-based treatment, compared with 2014-15, equivalent to 35% of those with diagnosable mental health conditions.	Access
	In addition to the 70,000 target, by 2023-24, 345,000 additional children and young people (aged 0–24) to have access to support via NHS-funded mental health services and school- or college-based Mental Health Support Teams.	
	For children and young people's eating disorder services, by 2020-21 (and thereafter), 95% of children in need receive treatment within one week of first contact with healthcare professionals for urgent cases, and four weeks for routine cases.	Waiting times
Perinatal services	By 2023-24, at least 66,000 women with moderate to severe perinatal mental health difficulties to have access to specialist community care (including evidence-based psychological therapies). Interim target for 2021-22 was 57,000 women.	Access
Improving community mental health services		
In addition to the headline targets below, the programme also monitors the early intervention psychosis standards as detailed above.		
Integrated care	By 2023-24, 370,000 adults and older adults with severe mental illnesses (SMI) to access integrated primary and community mental health care. Interim target for 2021-22 was 126,000.	Access/ integration
Individual placement and support	By 2023-24, 55,000 people a year to access Individual Placement and Support services. Interim target for 2021-22 was 32,000.	Access/ integration
Physical health checks	By 2023-24, 390,000 people with SMI receiving annual physical health checks. Interim target for 2021-22 was 302,000.	Integration
Expanding the mental health workforce		
	To support the FYFV and LTP commitments, an estimated additional 48,000 NHS-funded posts (full-time equivalent) needed by 2023-24, from a 2016 baseline of 214,100 (which included an estimated 20,100 vacancies). Interim estimate for 2021-22 was 32,000.	Workforce

Figure 4 *continued*
Overview of main milestones for mental health service improvement, in relation to access and waiting time standards, improving community mental health services, workforce, funding and data

Selected main milestones	Detail of main milestones	Type of milestone
Increasing funding for mental health services		
	From 2015-16, achievement of the Mental Health Investment Standard, which required clinical commissioning groups (and from 2022, integrated care boards) to increase annual spend on mental health services at a faster rate than their overall allocation. Renewed general commitment in 2018 to increase investment in mental health services faster than the overall NHS budget overall for the period up to 2023-24, to be supported by the Mental Health Investment Standard.	Funding
	From 2018, funding for children and young people's mental health services to grow faster than both overall NHS funding and total mental health spending.	
Improving data and information		
	By 2020-21, all providers, including non-NHS providers, to submit comprehensive data to the main Mental Health Services Data Set (MHSDS) and IAPT (talking therapies) dataset.	Data
	By 2023-24, all mental health providers to achieve Data Quality Maturity Index scores of or above 95%, for the main MHSDS.	

Note

1 FYFV = *Five Year Forward View for Mental Health*; LTP = *The NHS Long Term Plan*; NICE = The National Institute for Health and Care Excellence, IAPT = Improving Access to Psychological Therapies. The table combines separate targets/estimates from FYFV (up to 2020-21), Stepping Forward (up to 2020-21) and LTP (up to 2023-24). Not all programme metrics and interim annual milestones shown.

Source: National Audit Office summary of *Five Year Forward View for Mental Health*, Stepping Forward and *The NHS Long Term Plan* documentation and implementation plans

1.10 Our review of the national programme identified a number of strengths[9], including:

- bringing a clear and consistent focus and set of objectives to service expansion and improvement, with clear lines of accountability and ownership and strong leadership from the national team;
- its approach to sharing lessons and good practice, and stakeholder engagement, with most trusts and ICBs in our surveys finding NHSE support and guidance helpful; and
- a proactive approach to understand and address risks to progress, using a combination of bespoke local monitoring, assurance and support, centrally led actions, and regular national, regional and local engagement, although it had not been able to fully address some major risks to achieving its aims (see Parts Two and Three).

9 To assess the programme, we used a framework derived from our previous work on major projects and programmes. This allowed us to consider those factors we have considered important to the successful delivery of a programme.

Future developments

1.11 In 2023, NHSE, HEE and NHS Digital are merging (NHS Digital from 1 February and HEE from 1 April), with a planned 30%-40% reduction in overall headcount, simplifying functions at national, regional and ICB level and integrating regional NHSE and HEE teams. NHSE also intends to give the new local ICBs 'space to lead'. We assessed that the national programme had helped keep mental health as a priority for local areas. However, given the national and local reorganisations, we also identified an increased risk to mental health services getting sufficient attention as oversight and accountability arrangements — which tend to focus on acute care — develop.

1.12 In the light of disruption from the pandemic, NHSE has now announced delays of at least a year to achieving some of the original LTP ambitions for 2023-24. The 2023-24 planning guidance for NHS trusts and ICBs sets out a reduced set of six national objectives for mental health, although three do not yet have a specific target (for example, improving access to talking therapy services).[10] For LTP commitments not covered by the national objectives (for example, on eating disorder services for children and young people), the guidance asks local areas to set out their plans for progressing these. NHSE will also maintain the mental health investment standard until at least 2024-25 (Figure 4).

1.13 In 2022, NHSE consulted on new waiting time standards for community mental health and A&E mental health services, which would represent a major extension of the standards into new service areas.[11] However, it has not confirmed whether these will be implemented. NHSE told us that to implement the proposals, it will have to secure additional funding, better understand the gap between current performance and the new standards, address data quality and coverage issues, and define new and potentially complex metrics.

10 The six national NHS objectives for 2023-24 related to mental health are to: improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0–24 accessing NHS-funded services (compared to 2019); increase the number of adults and older adults accessing IAPT treatment; achieve a 5% year-on-year increase in the number of adults and older adults supported by community mental health services; work towards eliminating inappropriate adult acute out of area placements; recover the dementia diagnosis rate to 66.7%; and improve access to perinatal mental health services.

11 The proposed new standards comprise targets of: (a) four hours before being seen for 'very urgent', and 24 hours for 'urgent', presentations at community-based mental health crisis services; (b) one hour before receiving a face-to-face assessment following a referral from A&E or equivalent services for children and young people; and (c) four weeks before receiving help from a request for services at community mental health services.

1.14 NHSE will need a sound value-for-money basis on which to prioritise further expansion but we found limitations in the extent to which the national programme could assess relative value for money and return on investment.

- To select the initial areas for the new access and waiting time standards, DHSC and NHSE considered a range of criteria, and used methods such as stakeholder consultation and evidence reviews.[12] However, cost-benefit analysis was limited by available data and we did not see detailed analysis on appraisal of different options, nor any evidence to support the decision to prioritise waiting time standards for eating disorders for children and young people.
- As it has progressed, the programme has commissioned evaluations of new initiatives (such as Mental Health Support Teams) and accessed evidence about the clinical effectiveness of individual interventions. It has an ongoing programme of work to improve data on patient outcomes, and on costs of services.
- However, it still lacks good quality, systematic information on costs, benefits, return on investment and value for money for different interventions that could inform future priorities for development. For example, an April 2021 benchmarking report on adult crisis and acute mental health care noted a lack of data on service demand, capacity, activity and outcomes, with unexplained variations in measures such as receipt and acceptance of referrals.

12 The criteria included: clinical relevance and benefit, number of people potentially benefitting, measurability, service change needed, cost-effectiveness of standard, and patient/service user interest. The assessment drew on existing evidence, stakeholder consultation and new commissioned analysis.

Achieving parity of esteem

How the current NHS improvement programme contributes to parity of esteem

1.15 The current NHS programme represents the first steps of a longer journey to obtain full parity of esteem between NHS physical and mental health services. However, DHSC and NHSE have not defined, in operational terms, what fully closing the gap between physical and mental health services would entail. In our view, this should include, for example, the estimated proportion of people in need that different services should ultimately cover, the desired staffing profile, and share of funding between mental and physical health services. Without a definition and associated measures, it is not possible to say how far the current improvement programme takes the NHS towards full parity of esteem.

1.16 We accept NHS England's argument that, even under a full parity of esteem scenario, it would not expect 100% of all people with mental health needs to need NHS treatment. However, as of 2021-22, there was still a large treatment gap: we estimated that roughly around one in three people with mental health needs accessed services. The main limitation to how fast services can expand is the workforce. For example, for the LTP, NHSE noted as a main constraint the level of achievable growth in the medical workforce, particularly psychiatrists, who take at least 12 years to train. It planned greater short-term growth in therapist staff, and in service areas and staffing models with less reliance on clinical time.

1.17 This means that, under current programme plans up to 2023-24 and even if the NHS achieves all its access targets, there will still be a sizeable gap between the number of people with mental health conditions and the number of people that the NHS can treat.[13] Based on available data and modelling for prevalence of mental health needs, we estimated the size of this gap for two service areas.

- For talking therapy services, the 2023-24 target for 1.9 million people to access services equates to around one quarter of people with a diagnosed need.
- For children and young people's mental health services, the stated 2023-24 access target equates to around two-fifths of young people aged 0—17 with a diagnosable need accessing services.

13 Most of NHSE's access targets are for absolute increases, for example, x more additional people, while some are for coverage of the population in need, for example, x% of people in need. Using an absolute number is a practical approach for short-term operational targets, and for planning increases in workforce and infrastructure. Using the treatment gap as a target can be more difficult operationally because it also depends on the overall prevalence of need in the population, which may go up or down. However, it is an important measure to consider in its own right to determine whether services are meeting the needs of the population and what capacity may be needed in the long term.

The role of prevention

1.18 Previous government strategies emphasised the importance of improving preventive services for mental health and wellbeing alongside treatment for mental illness.[14] The NHS programme primarily covers clinical treatments, with only limited investment in areas relating to prevention, for example, mental health support teams in schools.

1.19 In April 2022, the government set out actions it had taken on prevention, such as launching the online advice service Every Mind Matters, introducing compulsory relationship, sex and health education in schools, and setting up the debt help initiative Breathing Space.[15] However, we heard strong concerns from local government and other stakeholders about a continued lack of funding for preventive services. Between 2018-19 and 2022-23, the local authority public health grant had a real-terms reduction of 6%.[16] Although the amount of local authority spend on public mental health has increased in recent years (in cash terms, from £42.7 million in 2016-17 to £86.6 million in 2021-22), it only accounts for around 2% of their total spend on public health. In a July 2022 survey of directors of adult social services, 78% of respondents reported an increase in the number of people approaching their local authorities with mental ill health, with this increased demand requiring an estimated additional £92 million of funding in total for 2022-23.

1.20 Together with other areas of government, DHSC is responsible for investment in preventive services. In April 2022, the government consulted on plans for a new 10-year cross-government strategy on mental health and wellbeing, but this has not been published. In January 2023, the government announced that it would develop a major conditions strategy, aimed at tackling the six major conditions which contribute to ill health, including mental ill health, for the next five years. Our October 2022 report on the introduction of integrated care systems found that DHSC and NHSE would need to take action to ensure that local systems could make progress on prevention.

14 Preventive services and support encompass a wide range of universal and targeted approaches aimed at stopping mental health problems before they start, promoting good mental health, supporting those at higher risk of experiencing mental health problems, and helping people living with mental health problems to stay well. They are provided by a wide range of different bodies, including local authorities, schools, voluntary providers and NHS and other healthcare providers. Examples include parent and child groups, self-help and community groups, public campaigns, mental health education in schools, colleges and universities, or mental health first aiders in workplaces. Some services address issues known to affect mental health, such as supported housing, employment support and debt advice services, while others may be for groups known to be at greater risk of mental health problems, such as LGBT people or rough sleepers.

15 Every Mind Matters provided online advice and support to help people look after their own wellbeing. Breathing Space was an initiative which could freeze interest, fees and charges on debts, and pause enforcement action, for eligible individuals.

16 This excludes separate targeted investment in this period, for example, for drug treatment services.

Part Two

Improving services for patients

2.1 Part Two covers the progress made by the NHS to improve NHS mental health services, including improving access to timely treatments, patient experiences and outcomes and reducing mental health inequalities.[17]

Improving access to timely treatments

Access to NHS mental health services

2.2 The number of people accessing NHS mental health services has generally increased, reflecting NHS England's (NHSE's) overall ambitions (**Figure 5** overleaf).

- Referrals to NHS mental health services increased by 44% between 2016-17 and 2021-22 (from 4.4 million to 6.4 million).
- *The NHS Long Term Plan* (LTP) aimed to increase the number of people accessing NHS mental health services by two million between 2014-15 and 2023-24. However, due to the lack of a consistent baseline from 2014-15 and the increase in service providers submitting data since 2016-17, it is hard to assess whether the NHS is on track to achieve this ambition. Between 2016-17 and 2021-22, the number of people in contact with NHS mental health services reported to NHS Digital increased from 3.6 million to 4.5 million people.

2.3 Unlike general acute NHS services, the number of people with mental health conditions treated by the NHS has increased during the COVID-19 pandemic, following a small drop in 2020-21. However, the increase in capacity has still not met the demand. In 2021, NHSE produced indicative estimates which suggested that the majority of people with a mental health need – an estimated 8 million – were not able to access NHS services.[18]

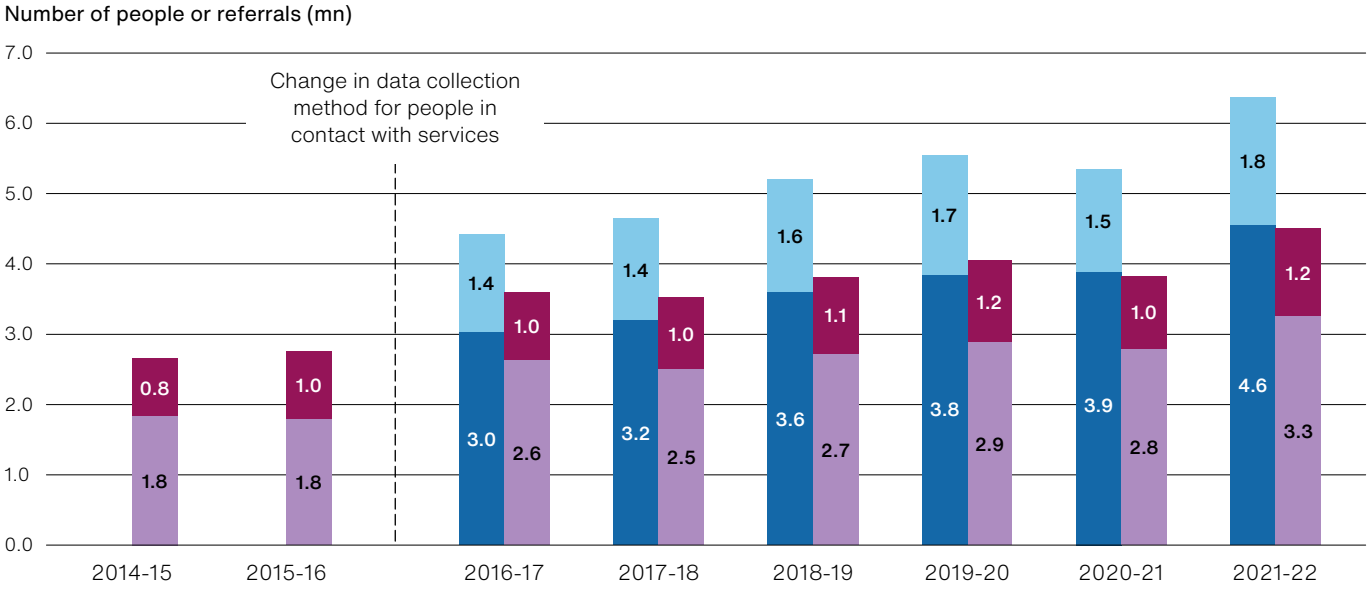
17 As noted in Part One, 'NHS mental health services' includes mental health treatment services provided directly by NHS trusts or GPs, as well as services funded by the NHS but commissioned from non-NHS providers.

18 In the absence of more reliable and up-to-date prevalence survey data (which are scheduled for publication in 2024-25), NHSE estimated this from multiple available sources including past data on prevalence, the Office for National Statistics surveys and other ad hoc studies.

Figure 5

Trends in referrals to and the number of people in contact with NHS mental health services in England, 2014-15 to 2021-22

More people are now accessing NHS mental health services than before



Notes

1 Referrals to and contacts with mental health services include learning disability and autism services. People in contact with NHS mental health services in any one year include not only people referred to the services in that year but also people who continue to access these services after being referred in previous years. A person who received both talking therapies and other NHS mental health services during the same year is included as two different people in contact with services.

2 Data on the number of people in contact with NHS mental health services (excluding talking therapy services) are not fully comparable between 2016-17 onwards and earlier years. For 2014-15 and 2015-16, this number was based on the Mental Health and Learning Disabilities Data Set (MHLDDS), but from 2016-17, it has been based on the Mental Health Service Data Set (MHSDS). This change resulted in a large one-off increase in the number of people in contact with services. The number of providers submitting data to MHSDS has also increased from 85 in 2016 to 364 in June 2022 and some of the reported increase in the number of contacts could be due to the increased data submission.

Source: National Audit Office analysis of published NHS Digital data

2.4 As set out in **Figure 6** overleaf, the NHS also set access targets for specific service areas. Performance against these has been mixed, with progress affected by the COVID-19 pandemic in different ways.

- For its 2023-24 commitment to support additional children and young people, the NHS was 3% below its interim target for 0- to 17-year-olds by 2021-22. Prior to the pandemic, NHSE assessed that, as at June 2020, it was ahead of progress towards the 2023-24 commitment, having achieved an earlier 2020-21 ambition to treat an additional 70,000 0- to 17-year-olds as set out in its *Five Year Forward View for Mental Health* (FYFV).
- For talking therapies, the NHS did not meet the target before the pandemic, in part due to not expanding the workforce as required. Increasing complexity in cases following the pandemic has exacerbated the situation. In 2021-22, 1.2 million people accessed the service, 22% below the target of 1.6 million for that year. The gap widened from 10% in 2019-20.
- In contrast, the national rollout of 24/7 mental health crisis telephone helplines was brought forward to May 2020 in response to the pandemic and by the end of March 2022, provisional data indicated that 64% (from 7% in 2016) of hospitals had 24/7 mental health liaison services, ahead of planned targets.

Waiting times standards

2.5 From 2015, NHSE introduced specific waiting times standards for three service areas, which set ambitions for people to enter treatment quickly. The standards are set out in **Figure 7** on pages 31, 32 and 33, and covered Improving Access to Psychological Therapies (IAPT) or talking therapy services, early intervention in psychosis services, and eating disorder services for children and young people.

2.6 The NHS made good progress against these standards until 2019-20 but the pandemic has disrupted performance (Figure 7). Since the pandemic began and activity has increased, performance against waiting time standards for talking therapy services and early intervention in psychosis has fluctuated but standards were consistently met. However, for eating disorder services for children and young people, the NHS has never met the 95% targets for urgent or routine cases that it aimed to meet from 2020-21. Performance was improving before the pandemic but deteriorated during and after it, in the face of particularly large increases in demand and activity. For example, during April–June 2022, 68% of urgent and 69% of routine cases were seen within the standard (a target of 95%), compared to 88% and 87% respectively in April–June 2020.[19]

19 For example, during April–June 2022, the number of children and young people treated for eating disorders was 63% higher for urgent cases, and 73% for routine cases, compared to April–June 2020 when the 95% standard was first introduced.

Figure 6

Progress in improving access to NHS-funded mental health services, as at 2021-22

Performance against specific access targets has been mixed, with progress affected by the COVID-19 pandemic in different ways

Targets by 2023-24	Expected by 2021-22	Actual by 2021-22
Children and young people (CYP)[1]		
345,000 additional CYP aged 0–25, on top of 70,000 additional 0–17-year-olds by 2020-21, to have access to support via NHS-funded mental health services and school/college-based Mental Health Support Teams, compared with 2014-15	0–17: 177,820 18–24: 8,916	0–17: 160,521 (10% below target) 18–24: 20,647 (132% above target which may also reflect impact of improvement programmes for adult services)
840,254 0–17-year-olds to be supported by an NHS-funded service or school/college based Mental Health Support Team	0–17: 691,784	0–17: 674,485 (3% below target)
Adults and older adults		
1.9 million adults and older adults have access to talking therapies for common mental illnesses (IAPT)	1.6 million	1.2 million
390,000 people with adult Severe Mental Illnesses (SMI) will receive a physical health check	302,000	226,583
55,000 people a year will have access to Individual Placement Support (IPS) services	32,000	15,230
66,000 women to access specialist community perinatal care	57,000	43,656
Crisis and liaison		
100% coverage of age-appropriate 24/7 crisis care through 111	No interim targets set	100% coverage of crisis lines (although not all linked to 111) and 98% of 24/7 Crisis Resolution Home Treatment teams
All general hospitals have 'core 24' mental health liaison services	59% of Liaison Mental Health Teams achieving 'core 24' standard 100% sustainability and transformation partnership (STP) coverage of liaison mental health teams	92% of hospitals have a 24/7 liaison service and 64% were at 'core 24' or an approved equivalent model in place as of March 2022 (provisional data)

■ Targets met or on track ■ Mixed progress ■ Targets missed or not on track

Notes

1 For the children and young people's mental health access ambition, NHS England (NHSE) measures the progress separately for 0-17 and 18–24-year-olds to ensure progress for each age group. It notes that access to services for 18-24 year olds may be affected by programmes to improve services for adults, as well as for children and young people. As a result, it expects the increase in access to services by 18-24-year-olds to be greater than that set out in *The NHS Long Term Plan* under the children and young people's mental health programme. It has not set an overall target for the total number of 18-24-year-olds accessing services beyond the expansion set out within the 0-25 ambition, but it does monitor progress across all programmes. During 2021-22, a total of 230,598 18–24-year-olds accessed NHS-funded mental health services against an expected number of 218,867.

2 The 64% of 24/7 liaison services is a provisional estimate by NHSE before the publication of its official Psychiatric Liaison Survey.

3 'Core 24' refers to hospitals with emergency departments that operate 24 hours, 7 days a week having core mental health services available 24 hours, 7 days a week.

Source: National Audit Office review and analysis of NHS England and NHS Digital data, and Mental Health Programme Board documentation

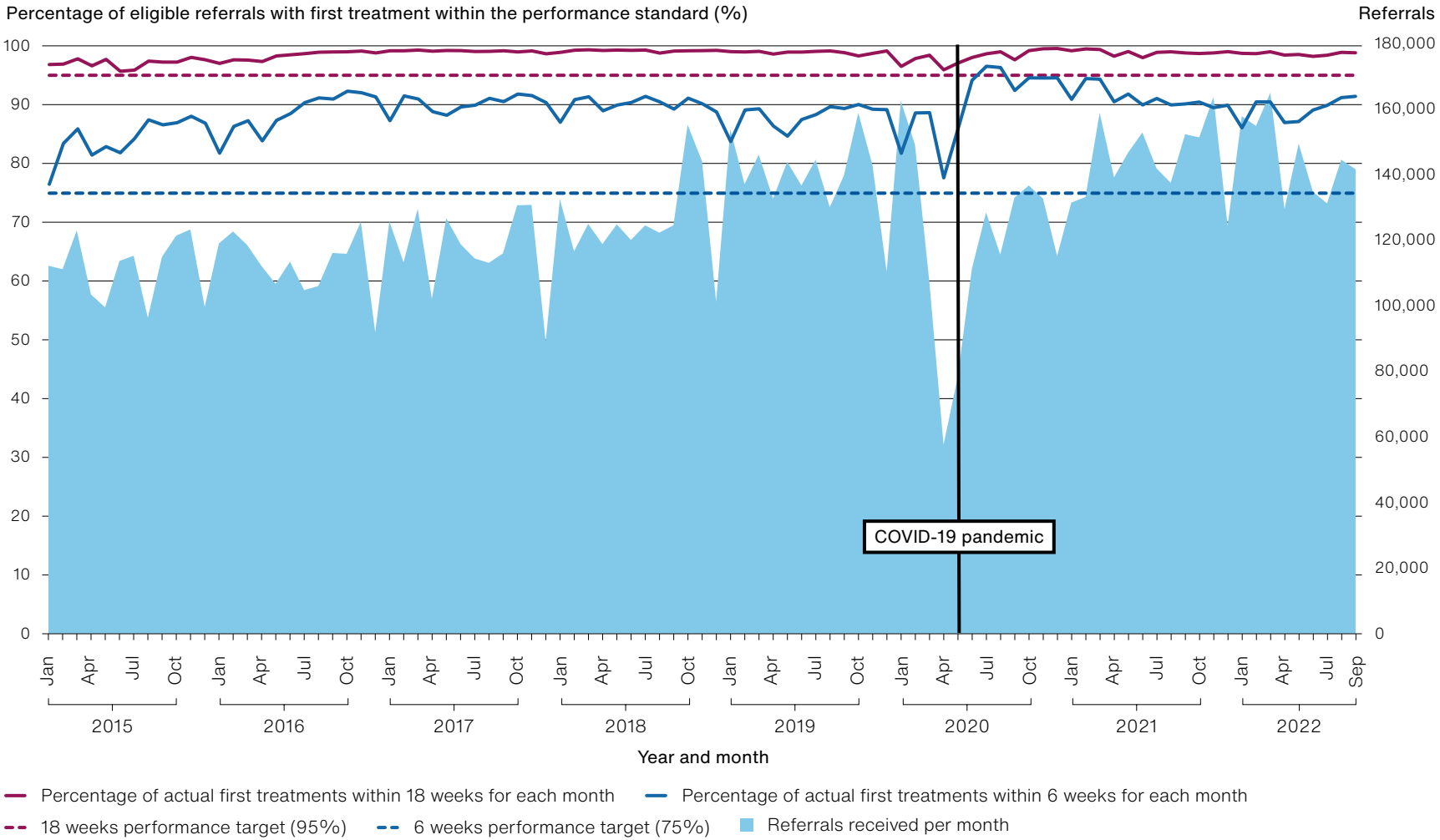
Post publication this page was found to contain an error which has been corrected (Please find published Correction Slip)

Figure 7

Trends in access to NHS funded mental health services and waiting times in England, 2015 to 2022

Progress in improving access to NHS mental health services and waiting times was disrupted by the COVID-19 pandemic and recovery since has been mixed

Performance against waiting time standard for talking therapy or Improving Access to Psychological Therapies (IAPT) services: 75% to be treated within six weeks and 95% within 18 weeks, January 2015 to September 2022



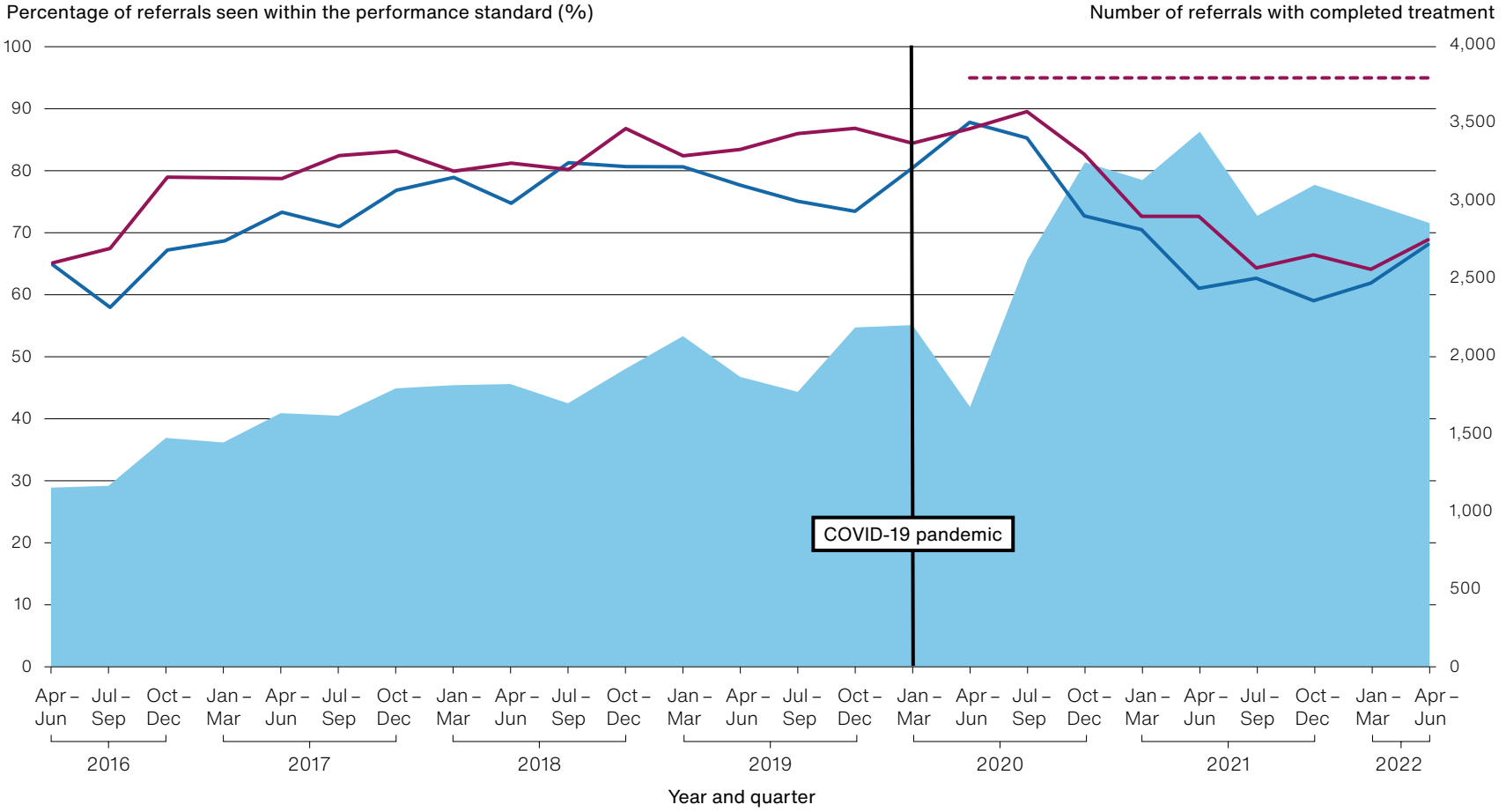
Note

1 The chart shows monthly IAPT service data from January 2015.

Figure 7 *continued*

Trends in access to NHS funded mental health services and waiting times in England, 2015 to 2022

Performance against waiting time standard for eating disorder services for children and young people: 95% to be treated within four weeks of first contact with healthcare professionals for routine cases and one week for urgent cases, April 2016 to June 2022



Notes

1 The chart shows quarterly children and young people's eating disorder service data, available from quarter 1 2016-17 (April–June 2016).

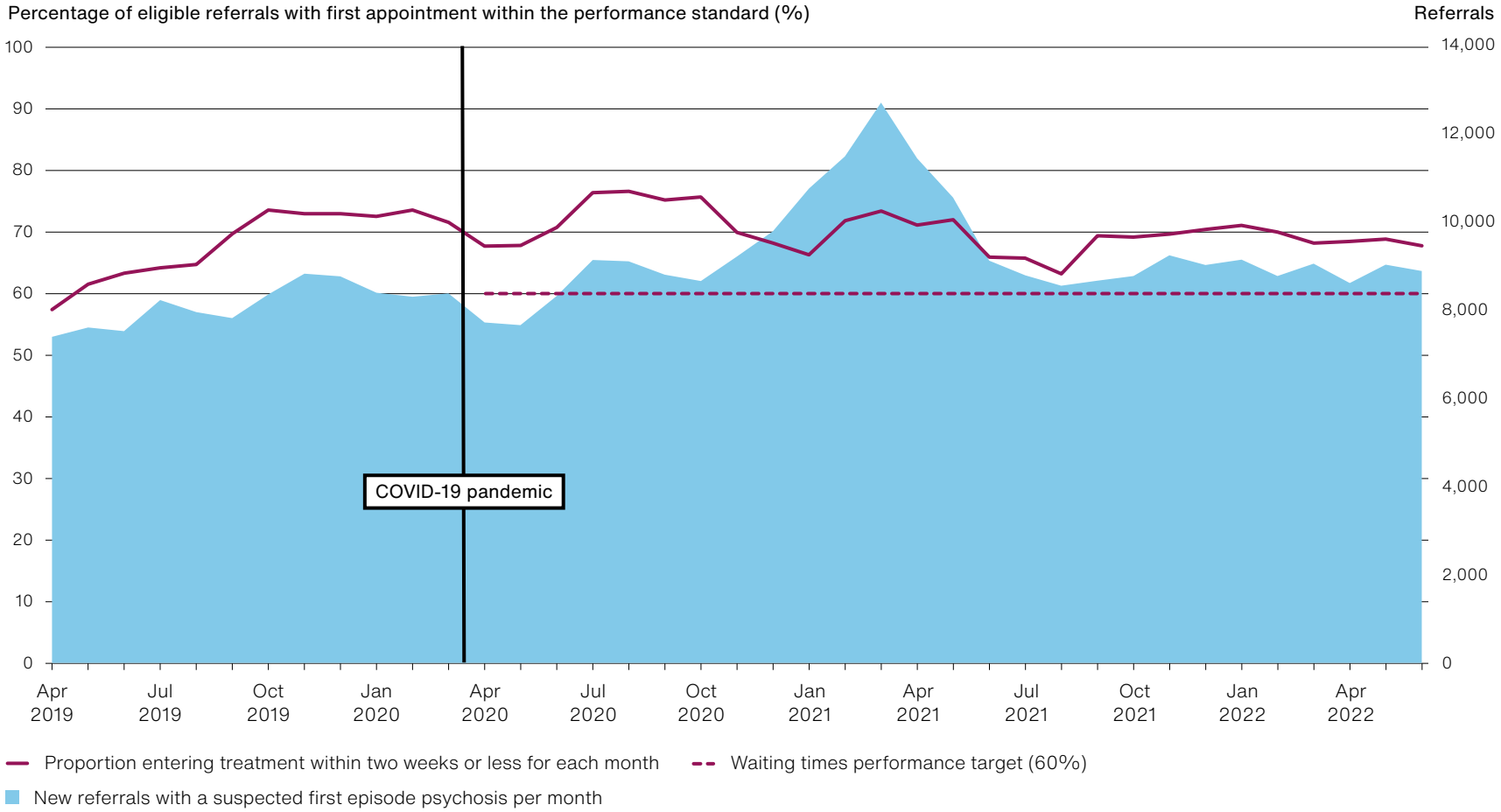
2 The 95% children and young people's eating disorder service standards were not implemented until 2020-21.

3 Due to a cyber incident affecting some providers' submission of mental health data to NHS Digital, it was not possible to update the data for children and young people's eating disorder services to September 2022, as originally planned.

Figure 7 *continued*

Trends in access to NHS funded mental health services and waiting times in England, 2015 to 2022

Performance against waiting time standard for early intervention in psychosis (EIP) services: 60% to be treated within two weeks of referral, April 2019 to June 2022



Notes

1 The chart shows monthly EIP service data from April 2019.

2 The 60% EIP service performance standard was not implemented until 2020-21.

3 Due to a cyber incident affecting some providers' submission of mental health data to NHS Digital, it was not possible to update the data for EIP services to September 2022, as originally planned.

Source: National Audit Office analysis of NHS Digital reports on the use of IAPT services and Mental Health Services Monthly Statistics; and NHS England Children and Young People with an Eating Disorder Waiting Times statistics

2.7 The main metrics used to assess waiting times performance are useful headline indicators of performance. However, they may not fully reflect people's experiences and may underestimate the amount of time people have to wait for treatment, and therefore the pressure that services are under.

- The standards will not cover everyone referred to treatment, for example, those who drop out without an appointment before or during treatment. These exclusions can make up a large proportion of referrals. For example, for talking therapy services, 61% of referrals in July–September 2022 were not included in the calculation of waiting times, as they did not complete at least two treatment sessions. This covers people who dropped out before their first treatment appointment, or who were treated and discharged after one appointment.
- The main metrics do not fully capture fluctuations in the number of 'long waiters' (people still on the waiting list or waiting for their first appointment after referral). For example, for talking therapy services, in September 2022, 9% of people (8,806 cases) on the waiting list had been waiting more than 18 weeks, compared to 7% (7,413 cases) in September 2019. Similarly, for eating disorder services for children and young people, in April–June 2022, 44% of urgent cases and 38% of routine ones had been waiting longer than 12 weeks for treatment (compared to 5% and 19% in April–June 2020).
- For talking therapy services, the standards refer to the time between referral and the first treatment. They will not reflect any delays occurring immediately after the first treatment appointment. For example, the proportion of people waiting longer than 90 days between their first and second treatment increased from 8% in April–June 2015 to 23% in July–September 2022.

The use of access targets and waiting time standards

2.8 The introduction of access and waiting time standards for mental health services from 2015 was an important first step towards parity of esteem with physical health services, where the NHS has used such measures to manage services since 1991. In our interviews, most stakeholders told us that the introduction of the new access and waiting time standards had helped to improve services, by increasing transparency, providing a focus for attention and quantifying gaps in performance. In our surveys, most integrated care boards (ICBs) (22 out of 27) and trusts (19 out of 34) agreed that their introduction had helped efforts to improve services. However, unlike waiting time standards for all elective physical health care, the waiting time standards for mental health only covered three specific service areas, alongside a number of access and service coverage targets (Figure 6). They did not apply to the bulk of core community and inpatient mental health services. Some stakeholders highlighted other limitations to the use of standards, for example, that the standards did not focus on improving service integration or outcomes.

2.9 In 2021-22, NHSE started publishing a national estimate of the number of people waiting for community-based NHS mental health services. This trial estimate includes talking therapy services, but excludes inpatient services, and does not set out the length of time people have waited.[20] By contrast, for physical health services, since 2007, the NHS has routinely monitored the overall number of people on the waiting list for all services by length of waiting time, with defined waiting time standards and performance set out for individual service areas.

Pressures on services and patient care

2.10 **Figure 8** overleaf shows how demand and service pressures can affect service provision, based on responses to our survey of NHS mental health trusts. Most respondents had allowed waiting times and numbers of people waiting for treatment to increase, while a minority had raised treatment thresholds (15 out of 33) and reduced service provision in some areas (six out of 33). They had also changed how they provided support, for example providing more information/support to people on the waiting list and using more online services.

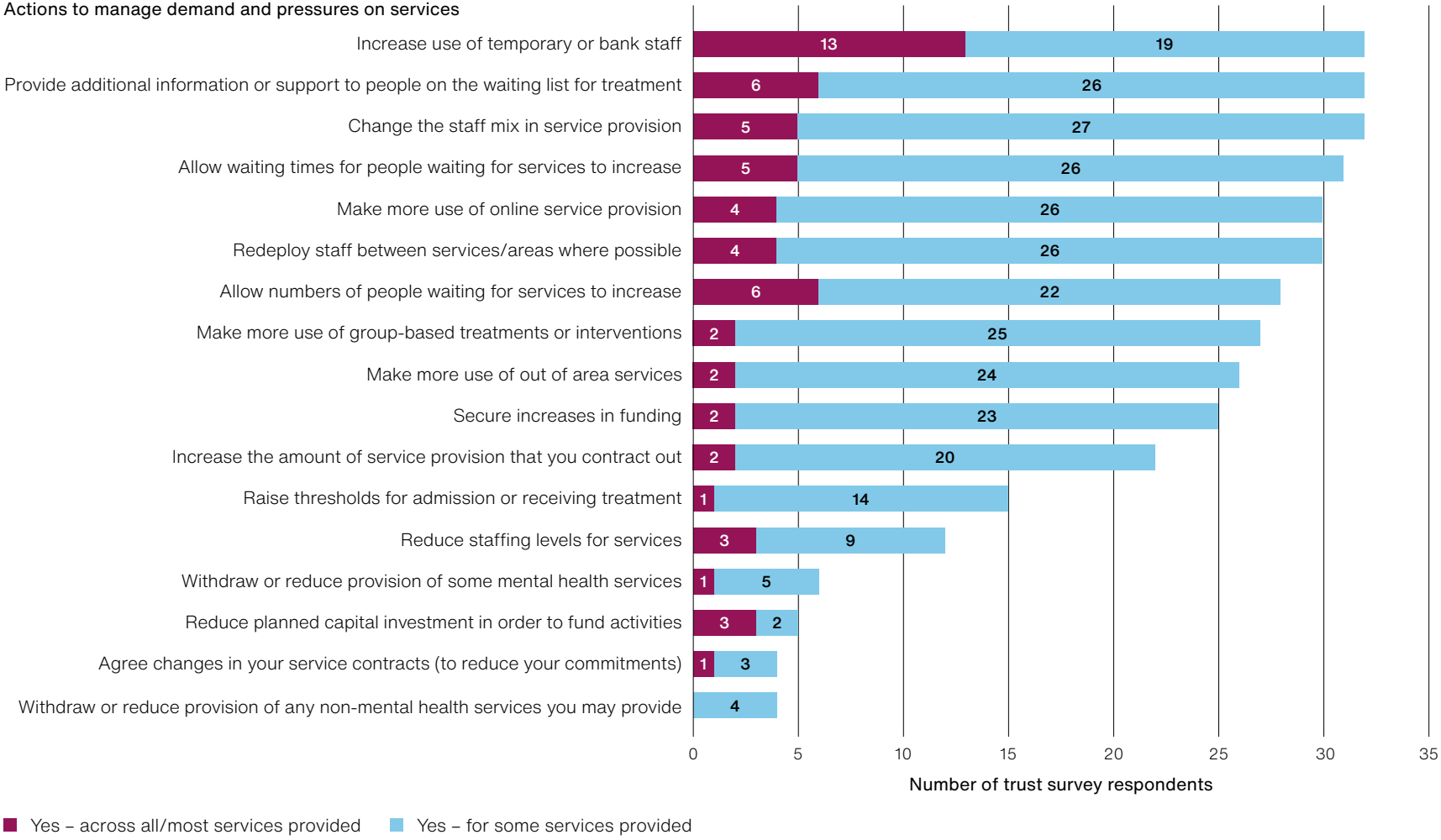
2.11 A number of other measures indicate rising pressure on mental health services, which can negatively impact patients (**Figure 9** on page 37). For example, there is a long-standing NHS ambition to eliminate the inappropriate placement of mental health patients in hospitals outside their usual local area, which can indicate a lack of local capacity and affect the continuity of people's care. However, this number has averaged more than 600 a month since April 2021. Other indicators, such as bed occupancy, also remain persistently high above the levels recommended for patient safety. NHSE and other stakeholders told us that the complexity of people's mental health needs is rising, in part driven by the pandemic, meaning people may need more, or more intensive, support. This is supported by available data, which indirectly measure complexity.

20 See Figure 9.

Figure 8

NHS mental health trust survey responses on actions they took to manage demand and service pressures

Most trusts had allowed waiting times and numbers of people waiting for treatment to increase to manage rise in demand and pressures on services



Notes

1 Mental health trusts comprise trusts solely providing mental health services, as well as combined trusts providing mental health services alongside community or acute health services.

2 Data were collected between September 2022 and October 2022. The overall response rate to the trust survey was 74%. The survey question asked: "Over the last year, have you had to do any of the following to manage demand and pressures on your service provision?" 33 trusts answered this question.

Source: National Audit Office survey of NHS mental health trusts

Figure 9

Indicators of pressure on NHS-funded mental health services in England

A range of indicators, including the number of people admitted into hospitals outside of their local area and high bed occupancy, suggest that NHS mental health services are under continued or increased stress

Indicators	Main concerns
Number of people waiting for mental health treatment	Number of people waiting for their second contact after being referred to community-based mental health (and learning disability) services increased from 1.0 million at the end of September 2021 to 1.2 million at the end of June 2022.
Mental health bed occupancy rate	Occupancy generally above recommended bed occupancy rate of not more than 85%. Rate for all beds ranged between 87%–90% during 2021-22 and first half of 2022-23, and rate for adult acute beds consistently at around 94% or more.
Children admitted to adult mental health wards	Between April and June 2019, a total of 72 children spent 426 days in adult wards. For the same period in 2022, the number of children went down to 50 children, but the number of bed days increased to 727 days. NHS England (NHSE) aims to eliminate inappropriate use of beds in paediatric and adult wards.
Number of mental health patients inappropriately placed in hospitals outside their local area (out of area placement)	Inappropriate out of area placements have averaged more than 600 a month for all but two months between April 2021 and September 2022, against a long-standing NHSE aim to eliminate them.
Number of people with mental health needs waiting longer than 12 hours in A&E	Increase between March and November 2021, when 11% of mental health patients waited more than 12 hours in A&E and 37% more than 6 hours.
Care Quality Commission inspection ratings	Little change in ratings since 2017. As of July 2022, 23% of mental health providers had an overall rating of 'inadequate' or 'requires improvement'. 38% had safety rating of 'inadequate' or 'requires improvement' (compared to 35% for acute trusts).
Rising complexity of mental health needs of people (acuity) needing services	Little quantifiable data available, but proxy indicators show: • increases in average number of treatment sessions for talking therapies from less than seven before the COVID-19 pandemic to about eight in 2021; and • increase of more than 40% in the number of people referred to specialist crisis services between March 2020 before the COVID-19 pandemic and March 2022.

Notes

1 An out of area placement is when a person with acute mental health needs who requires inpatient care is admitted to a unit that does not form part of their usual local network of services (treatments more than 50km from home). When placed out of area, the person cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning.

2 The number of patients in inappropriate out of area placements in a particular month includes both patients admitted during that month and patients admitted before that month who have not been discharged, based on figures as originally published.

3 Care Quality Commission 2022 ratings covered a total of 870 NHS and non-NHS mental health services.

Source: National Audit Office analysis and review of NHS Digital data, NHS England data and documentation, and Care Quality Commission reports and data

Developing more integrated, people-centred services in the community

Progress against ambitions to improve integration

2.12 The LTP set out ambitious plans to provide a more integrated service for people with mental health needs through the development of new community-based care models, based around primary care networks.[21] These aimed to better coordinate services and support across primary and secondary NHS services, and non-NHS services such as social care, housing and employment.[22] NHSE developed a new Community Mental Health Framework, which set out the principles for these new care models. Between 2019-20 and 2020-21, it supported 12 pilot sites to test the framework before rolling out the new care models to the rest of England.

2.13 The rollout of the new models is still in the early stages. To support it, NHSE will spend an additional £1 billion in community mental health services by 2023-24. In 2021-22, it allocated £400 million funding and all integrated care systems (ICSs) had set out their plans to improve community-based services.

2.14 By September 2022, NHSE reported that 34% of primary care networks had fully or partially implemented the new care models. NHSE has developed indicators to monitor the impact of changes to services on people's access. For example, the NHS aims to provide services to 370,000 people under the new care models by 2023-24. As of June 2022, 141,000 adults with severe mental illness (SMI) (81% of target) had received two or more contacts under a new community-based care model. NHSE also set a target to increase the total number of people accessing community mental health services by 5% each year. Data from July 2022 indicated growth of 2.4% over the previous 12 months. However, NHSE has yet to put in place indicators to measure progress on timeliness of care (for service areas not currently covered by the existing three waiting times standards, paragraph 2.5), quality of care, and patient outcomes, although a number of indicators are currently being developed and tested.

21 Primary care networks are networks of GP practices. They were established in 2019 across the NHS to support care integration in local communities, including working more closely with local NHS acute service providers.

22 NHSE also intended the rollout of provider collaboratives – formal partnerships that bring together two or more NHS trusts to work together at scale to benefit their populations – to improve integration. By September 2021, 30 out of 42 ICBs indicated they would have provider collaboratives for mental health in place. A 2022 Care Quality Commission review of provider collaboratives for children and young people's mental health services noted positive examples of collaborative working, as well as challenges including staffing, 'silo working' and health inequalities.

Challenges and risks to improving community-based services

2.15 The scale and complexity of change required in the timeframe may prove challenging. A summary by The King's Fund of lessons from the early implementer sites identified a number of success factors, including good local relationships across stakeholders, and capacity to develop new skills and ways of working. The King's Fund identified data-sharing and compatibility between services as an important area to get right for the new care models, one that the NHS has historically found it hard to make fast progress in. In addition, there is still a lack of good quality data on services and outcomes, needed to facilitate learning and understand progress.

2.16 We identified other barriers that the NHS must overcome to improve and join up community-based services.

- NHSE has identified the need to improve the estate for community mental health services, to provide enough space for treating more people, and desk capacity for more staff.
- From our surveys, most ICBs (16 out of 28) and about half of responding trusts (17 out of 34) cited a lack of joint commissioning with non-NHS or local authorities as a significant barrier to service improvement.[23]
- In addition to concerns from local government stakeholders about their capacity to engage in changing services, we heard strong stakeholder concerns about strains on GP capacity. GPs are an essential partner of mental health services, as a source of referrals to mental health services, and in managing people with ongoing needs in the community, but there is little national information available to assess sector activity, capacity and spend.

2.17 The introduction of ICSs offers opportunities to help overcome these barriers. In our survey, 26 out of 29 responding ICBs agreed that they were aware of the challenges in improving mental health services and 22 agreed that they were able to take a more strategic approach to planning and provision of services than previous clinical commissioning groups (CCGs) (**Figure 10** overleaf). However, only four agreed that they had the capacity, resources or staff required to improve services.

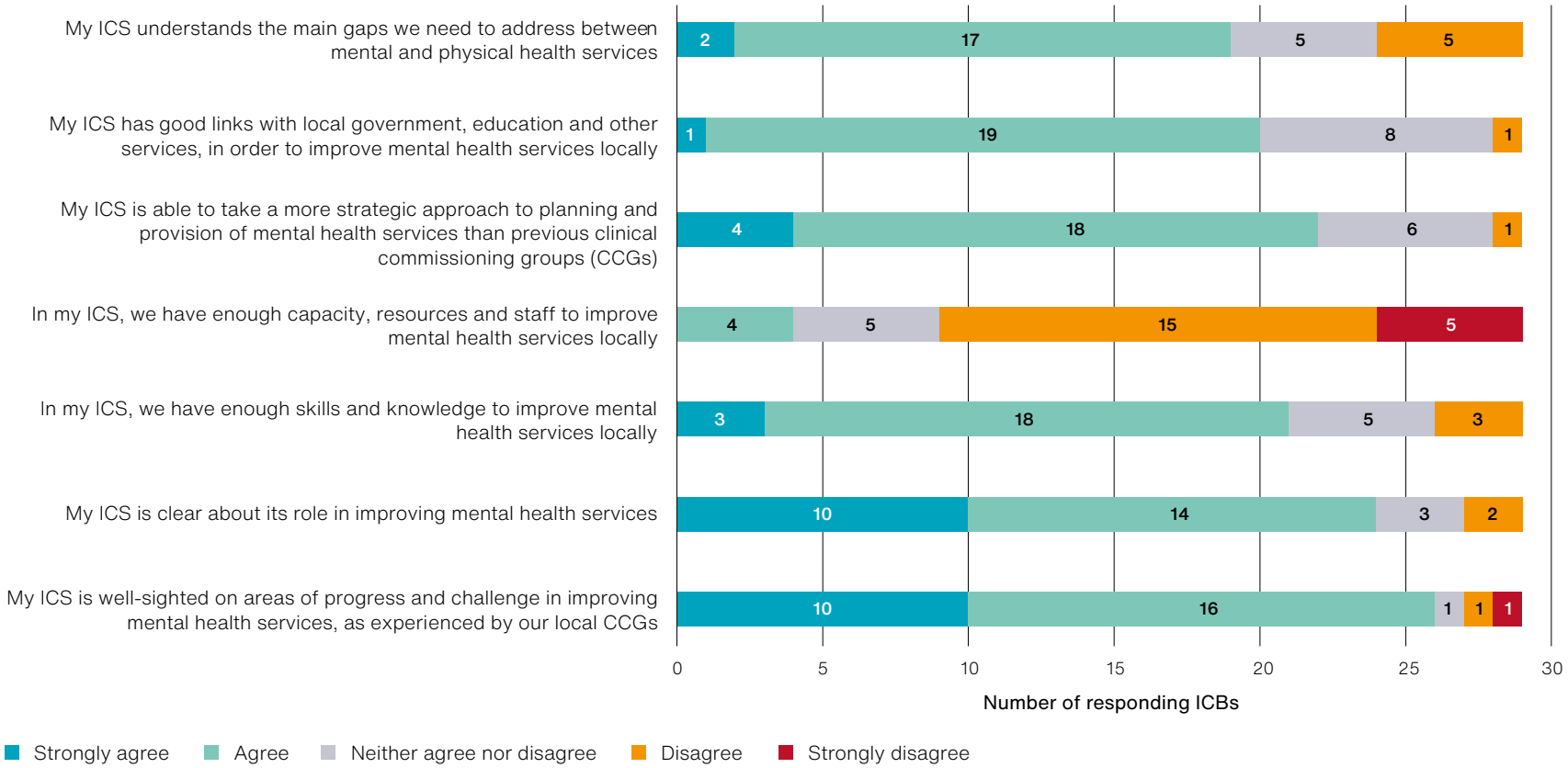
23 For a pre-specified list of factors, the survey questions for ICBs/trusts asked "to what extent have these been a significant barrier to efforts to improve mental health services (across your local area/in your trust)?" For report purposes, we describe respondents saying a factor was a "very" or "quite significant" barrier as noting a significant barrier. Other response options were: "slightly significant", "not significant at all", "don't know" or "not applicable".

Figure 10

National Audit Office survey of integrated care boards (ICBs) on their roles in improving mental health services

Most ICBs are confident about their knowledge of the challenges in improving mental health services in their areas but only 4 out of 29 agreed they have the capacity to do so

ICB statements about the role of integrated care systems (ICSs) in improving mental health services



Notes

1 Data were collected between September 2022 and October 2022. The overall response rate to the ICB survey was 67%. The survey question asked: "How much do you agree or disagree with the following statements about the role of ICSs in improving mental health services?" 29 ICBs answered this question.

2 ICSs are local partnerships of providers and commissioners of NHS services, local authorities and other local partners, which plan, coordinate and commission health and care services. ICBs are statutory ICS bodies responsible for allocating NHS budgets and commissioning NHS services.

Source: National Audit Office survey of integrated care boards

Experiences and outcomes for people using services

2.18 Despite the increase in numbers of people treated and efforts to improve services, many people are still having poor experiences with mental health services. In October 2022, the Care Quality Commission's (CQC's) *State of Care* report described the health and care system as 'gridlocked', highlighting general risks to quality of care and patient safety and particular concerns about children and young people's mental health services. The 2022 CQC community mental health survey found that people's experiences 'remain poor' and highlighted accessing care, crisis care, involvement in care and support and wellbeing as being 'poor over a number of years'.

2.19 Stakeholders we interviewed told us about their frustrations with the difficulty in getting access to services. Interviews highlighted particular issues for a number of groups, including children and young people, and their transition to adult services; people from minority ethnic groups; LGBT people; and people with more complex needs or more than one diagnosis.

2.20 Local areas reported a lack of information about user experiences and outcomes. In our survey of ICBs, only four (out of 29) said they had all or most of the data they needed to assess patient and user experiences, and none of them felt this in relation to patient outcomes. Nationally, routine information on outcomes is only monitored for talking therapy services, which has generally reached its target of a 50% recovery rate since 2016.[24] For other service areas, outcome measures are at a much earlier point in development, which in part reflects the complexity of doing so. NHSE has identified gaps in outcomes data as a risk and has work ongoing to develop outcome measures and guidance and to collect more data (see paragraphs 3.13 to 3.16).

2.21 In January 2023, the Department of Health & Social Care (DHSC) announced a rapid review into patient safety in mental health inpatient services, following the publication of an NHSE inquiry into the care of three teenagers at a trust and other media reports on patient safety and dignity. While this report does not investigate safety and quality of NHS mental health services in depth, these events, and other indicators of user experience and system performance, clearly indicate a service under high pressure.

24 Similarly to paragraph 2.7, this recovery percentage is based on people who have completed at least two treatment sessions. It excludes people who were referred but dropped out before they had their first appointment, or who were discharged after one treatment appointment. For July-September 2022, these exclusions accounted for 61% of referrals to talking therapy services, which would mean that only around a quarter or less of those referred would count as recovered.

Addressing inequalities

2.22 People with mental illness often have poorer health outcomes than those without. For example, people with an SMI are more likely to die prematurely than those without an SMI. Many factors, both outside and within the NHS, will contribute to this. The NHS aims to help reduce this inequality in life expectancy through improving its services for people with mental health needs (for example, by carrying out annual physical health checks for people with SMI). Recent analysis by NHS Digital suggests that the gap in premature mortality has widened: in 2015–2017, people with an SMI were 4.6 times more likely to die prematurely; this increased to 4.9 times more likely in 2018–2020.

2.23 There are also wide variations in access to and experiences of NHS mental health services, as well as inequalities in outcomes, with some examples set out below.

- People from minority ethnic groups have lower treatment rates, report poorer levels of satisfaction with community mental health services and have poorer recovery rates in talking therapy services. For example, during 2021-22, the proportion of people admitted to acute mental health services who were not known to services previously was 17% for people from minority ethnic groups, more than one-third higher than the proportion for people of White British origin, 12%. This indicates that people from minority ethnic groups were less likely to access preventive or community mental health services for treatment.
- Older people (aged 65 and over) are less likely to access treatment compared to other age groups. For example, in 2021-2022, the number of older people with common mental health conditions accessing talking therapy services was about 44% of target for their age group, compared to around 75% for all age groups.
- LGBT people tend to report poorer experiences of NHS mental health services but sexual orientation is only recorded for 11% of people in contact with services.

2.24 Tackling mental health inequalities has been an important policy objective for NHSE. In 2019, it set out expectations for local systems to reduce mental health inequalities by 2023-24. Its 2020 *Advancing Mental Health Equalities Strategy* prioritised a number of actions, including supporting local health systems to adopt population health approaches, improving data and information, and developing a more diverse workforce. A taskforce oversees the strategy; this has met quarterly since 2020. To encourage tackling mental health inequalities, NHSE told us that it provided funding of around £695 million in 2022-23 to ICBs on the condition that they have a clear plan in place to address inequalities in their area.

2.25 Data on variations in access to services and outcomes are now routinely published for some services, for example, talking therapy services and the annual mental health service bulletins. However, there continues to be a general gap in the understanding of variation in outcomes and experiences for different groups. In our survey of ICBs, only two out of 29 said they had all or most of the data they needed to assess variations in access, experiences and outcomes between different groups.

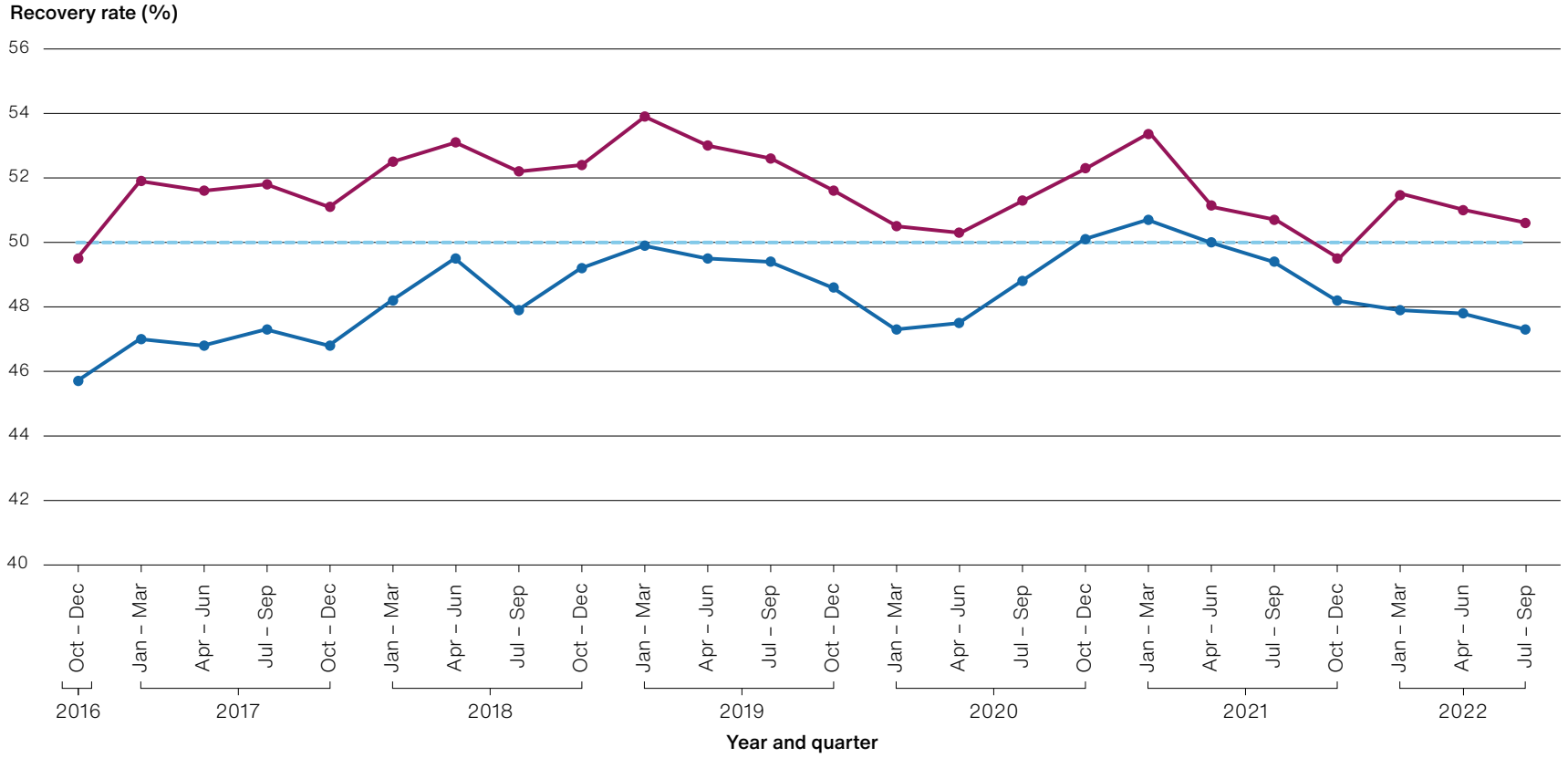
2.26 In 2021, the national programme started to monitor four indicators of inequalities on a trial basis. For example, one indicator was the rate of recovery following talking therapy treatment for patients from minority ethnic groups.[25] However, with many of the initiatives still in development, it is not yet clear what impact they have had on reducing inequalities. Data, where available, on the impact of NHSE's initiatives on reducing inequalities in patient experience and outcomes are variable. For example, for talking therapy services, the gap in recovery rates between people from minority ethnic groups and those of White British origin reduced slightly during the COVID-19 pandemic, but this has not been sustained (**Figure 11** overleaf).

25 The other three indicators were related to older people's access to IAPT (talking therapy) services, admissions of people who had no previous contact with NHS community mental health services in the prior year by ethnicity, and length of stay in acute mental health settings. NHSE also publishes detentions under the Mental Health Act for people from minority ethnic groups.

Figure 11

Recovery rates for talking therapy services by ethnicity, 2016 to 2022

The gap in talking therapy recovery rates between people from a minority ethnic group and those of White British origin reduced slightly during the COVID-19 pandemic, but this has not been sustained



Notes

1 Recovery is when a person is no longer experiencing the symptoms of anxiety and/or depression following talking therapy treatment. The recovery rate is calculated from the number of people completing treatment, which accounts for less than 50% of referrals. It excludes those who dropped out before being seen following their referral and those who did not complete their treatment.

2 The national recovery rate standard is that a minimum of 50% of eligible referrals should move to recovery.

3 The recovery rate for July–September 2020 is missing: we calculated an imputed recovery rate for that quarter, as the average of the recovery rates for the quarters before and after it.

Source: National Audit Office analysis of NHS Digital data

Part Three

Increasing mental health service workforce, funding and information

3.1 Part Three sets out progress in developing the workforce, funding and commissioning, and information for NHS-funded mental health services, and issues relating to future demand for mental health services.

Mental health workforce

Expanding the mental health workforce

3.2 In 2017, NHS England (NHSE) and Health Education England (HEE) published estimates of how many additional staff would be needed to deliver improved and expanded mental health services, with further NHSE estimates published in 2019. Overall, the NHS mental health workforce has increased in line with these sets of estimates. Between 2016-17 and 2021-22, NHS staff numbers grew by 22%, compared with the estimated requirement of 17% (**Figure 12** overleaf).[26] However, the rate of increase varies greatly by staff group. In particular, nursing numbers grew by less than HEE's and NHSE's estimated requirement (9%, compared to an estimate of 16%), while numbers of therapists and support staff for therapists[27] grew by substantially more (for example, a 41% growth in therapists compared to 25%).[28] There was also higher growth in workforce numbers for children and young people's mental health services (including non-NHS staff): these grew by 70% between 2016 and 2021, higher than the estimated requirement of 55% (Figure 12).

26 NHS Digital regularly publishes data on the mental health workforce for staff employed by NHS trusts. This excludes non-NHS staff providing NHS-funded services (for example, those employed by voluntary, charitable or independent providers). The ad hoc workforce data collections for talking therapy, and children's and young people's mental health services, estimated that around one-fifth of those workforces was employed outside the NHS.

27 By 'therapists', we mean NHS staff in the mental health workforce and classed in the staff group scientific, therapeutic and technical staff, as published by NHS Digital. By 'support staff for therapists', we mean NHS staff in the mental health workforce and classed in the staff group support to scientific, therapeutic and technical staff. See notes to Figures 12 and 14 for more details.

28 *Stepping forward to 2020/21: The mental health workforce plan for England* (Stepping Forward, July 2017) assumed that mental health workforce vacancy rates would reduce to around 10%. As of September 2022, available data on vacancy rates in mental health trusts for doctors (regional range of 9%-19%) and nurses (15%-24%) suggested they remained higher than this.

Figure 12

Trends in mental health workforce against initial estimates of requirements, 2011-12 to 2021-22, England

Overall, the NHS mental health workforce increased by 22% between 2016-17 and 2021-22

	Full-time equivalent staffing at the end of:				Percentage change		
	2011-12	2016-17	2020-21	2021-22	2012–2017	2017–2022	
	(000)	(000)	(000)	(000)	actual (%)	estimate (%)	actual (%)
Total NHS staff employed in trusts	**112**	**109**	**127**	**133**	**-2**	**17**	**22**
Medical staff	9	9	10	10	0	9	**13**
Nursing staff	44	41	44	44	-8	16	**9**
Therapists and other clinically qualified staff	14	17	22	25	25	25	**41**
Clinical support staff, of which:	42	40	49	52	-5	19	**30**
Support to doctors/nurses	36	33	38	38	-7	N/A	13
Support to therapists and other clinically qualified staff	6	7	11	14	13	N/A	113
Administrative staff	3	2	2	3	-23	5	**22**
Children and young people's mental health workforce (NHS and non-NHS staff)							
Core children and young people's mental health services	N/A	12 (Dec 2015)	20 (Mar 2021)	N/A	N/A	55	70

Talking therapies or Improving Access to Psychological Therapies (IAPT) workforce (NHS and non-NHS staff)

In 2016, Stepping Forward estimated 9,700 full-time equivalent staff in the adult IAPT service. The NHS ambitions equated to 4,500 additional adult IAPT staff (51% increase) between 2016 and 2021. However, because of a lack of a reliable baseline and interim measures, it is not possible to confirm whether or not achieved growth is in line with implied ambitions. Between 2019 and 2021, the IAPT full-time equivalent workforce grew from around 10,300 to 13,800, an increase of 33%.

- Actual growth somewhat more than initial estimates (5 percentage points or more)
- Actual growth more than initial estimates (less than 4 percentage points)
- Actual growth less than initial estimates

Notes

1 Full-time equivalent figures are based on NHS Digital data for staff employed by NHS trusts and classed as part of the mental health workforce. These exclude non-NHS staff, who may provide NHS-funded services. A small number (48 in 2022) of ambulance and ambulance support staff, midwives, and staff in unknown roles are included in the total workforce figures.

2 'Nursing staff' comprises the staff group nurses & health visitors, which includes a very small number (8 in 2022) of health visitor staff. 'Therapists and other clinically qualified staff' comprises the staff group scientific, therapeutic and technical staff. This primarily consists of therapists (in IAPT services) and scientists (which includes psychologists, psychotherapists and therapists in the mental health workforce, outside IAPT services). 'Support to therapists and other clinically qualified staff' comprises the staff group support to scientific, therapeutic and technical staff. This includes assistant psychologists, as well as new roles such as psychological wellbeing practitioners, mental health practitioners, and peer support workers. 'Administrative staff' comprises the following staff groups: senior managers, managers, central functions, and hotel, property & estates.

3 The 'estimate' column was calculated based on *Stepping Forward to 2020/21* and *The NHS Long Term Plan* (LTP) estimates of the additional staff required to deliver the *Five Year Forward View for Mental Health* and LTP. This includes non-NHS staff.

4 Bespoke collections were carried out for talking therapy (IAPT) and children and young people's mental health services, which include non-NHS staff. IAPT collections took place from 2014 but are not considered reliable before 2019.

Source: National Audit Office analysis of NHS Digital data and ad hoc Health Education England data collections and estimates as set out in *Stepping Forward to 2020/21* and the mental health implementation plan for *The NHS Long Term Plan*

3.3 Despite the overall growth, shortages in the mental health workforce have been a major constraint to improving and expanding services. Workforce is one of two national programme risks consistently rated 'red'. Our surveys of trusts and integrated care boards (ICBs) confirmed workforce shortages remained as one of the most significant barriers to improving services.[29] While some responding trusts noted issues across all staff groups, there were particular concerns about medical and nursing staff, and psychologists. Trusts in our survey reported a wide range of reasons for workforce shortages, including problems recruiting and retaining staff, a high turnover of staff between service areas, and competition for staff from other healthcare providers, and elsewhere (**Figure 13** overleaf). They also noted actions they had taken on workforce in response to recent demand and service pressures, such as using more temporary staff and changing staff mix (Figure 8 in Part Two).

3.4 Currently, levers for workforce growth are spread across local and national bodies. NHS trusts and healthcare providers create posts and employ staff locally and are responsible for recruitment and retention, with ICBs expected to support them in local planning and deployment. National bodies, particularly HEE, provide support and assurance for local planning, but have relatively few direct levers on workforce supply. For example, HEE supports local areas through provision of education and professional development, but is only directly responsible for commissioning medical under- and post-graduate places, which covers the pipeline for psychiatrists. The national programme has also undertaken targeted actions on workforce, such as salary support schemes for the talking therapies workforce when local numbers fell below target, or funding of additional roles such as peer support workers. The programme's broader focus has been on:

- **increasing workforce numbers** in 'traditional' clinical roles, such as doctors, nurses and therapists. Faster short-term growth in therapy-related posts was planned, reflecting the longer time needed to train medical and nursing staff;[30]
- **developing new roles to support new service models**, particularly more non-clinical roles, such as peer support workers, mental health and wellbeing practitioners, and mental health practitioners.[31] These would support envisaged new service models, with multi-disciplinary teams providing a broader range of treatment and support; and
- **upskilling the workforce** through the provision of education and training for existing staff, for example, to provide other clinical interventions, or building routes for non-clinical staff to progress to more clinical roles.

29 Twenty-six out of 34 responding trusts, and 21 out of 29 responding ICBs, said workforce shortages were a very significant barrier to improving services (and a further five trusts and ICBs said quite a significant barrier).

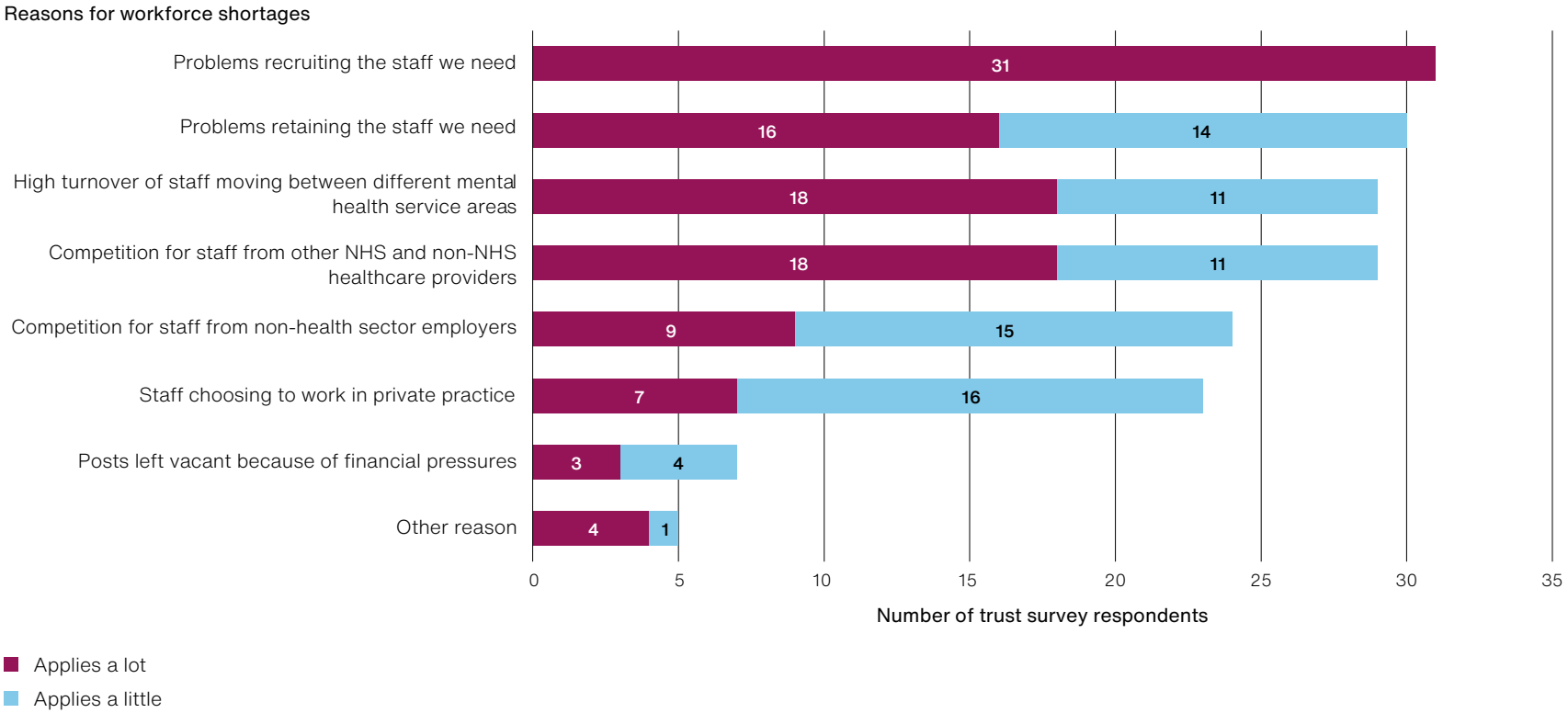
30 From starting medical school, it takes a minimum of 12 years to become a consultant psychiatrist. Junior doctors generally choose their specialism during core training (that is, psychiatry) and complete higher speciality training (for example, in old age psychiatry), before becoming a consultant psychiatrist.

31 Peer support workers, people who have experienced mental health challenges themselves, provide support to people using services. Mental health and wellbeing practitioners provide support and some psychological interventions (although not therapy). Neither of these roles require a degree. Mental health practitioners work in primary care settings, providing a combination of consultation, advice, triage and liaison, and are generally experienced mental health professionals, such as nurses or social workers.

Figure 13

NHS mental health trust survey respondents' views on reasons for workforce shortages

Trusts reported a number of different reasons for workforce shortages



Notes

1 Mental health trusts comprise trusts solely providing mental health services, as well as combined trusts providing mental health services alongside community or acute health services.

2 Data were collected between September 2022 and October 2022. The overall response rate to the trust survey was 74%, The survey question asked: "You said that workforce shortages were a very or quite significant barrier to improving mental health services. Below is a list of possible reasons for staff shortages – please indicate the extent to which each applies for your trust." 31 trusts answered the question.

Source: National Audit Office survey of NHS mental health trusts

3.5 In our surveys of ICBs and trusts, a number of respondents identified a robust long-term workforce plan, or action to increase training places and education opportunities to support new roles, as a priority for national bodies. However, as of 2022, and as has been the case for more than 25 years, the NHS still lacked a long-term workforce strategy. NHSE and HEE also did not meet a commitment to publish a five-year workforce plan, to support *The NHS Long Term Plan* (LTP), originally due in 2019. In November 2022, the government committed to publishing a comprehensive NHS workforce plan in 2023. The lack of a strategy makes it more difficult to achieve the more concerted and coordinated efforts needed across the whole system to achieve the workforce growth required. In addition, the HEE funding settlements for workforce education and training have been short-term and the timing and levels of agreed funding have not always aligned with the pipeline levels it estimated it needed for mental health. For example, for the LTP, which commenced from 2019-20, HEE only started to receive government funding for the supporting workforce education and training it estimated was required in 2021-22.

Managing other workforce risks

3.6 **Figure 14** on pages 51 and 52 sets out trends in a range of other workforce indicators for the mental health workforce. We highlight two particular workforce-related risks.

- In common with the wider NHS, the mental health sector may have to manage increased numbers of staff leaving after the COVID-19 pandemic. In 2021-22, 17,000 (12%) staff left the NHS mental health workforce, up from 13,000 (9%) in the pandemic year 2020-21, and pre-pandemic levels of around 14,000 (11%). The proportion of staff citing work-life balance reasons for leaving increased from 4% in 2012-13 to 14% in 2021-22. While the proportion leaving to retire had remained stable (at around one-fifth), the proportion of people in the mental health workforce who are closer to retirement has also increased, in particular, 22% of nurses were aged 55 and over.

- We heard concerns from stakeholders about a general diminishment of experience and a shift to less qualified staff in the workforce, with potential risks for service quality. NHSE and HEE anticipated that the number of staff in therapist and non-clinical roles would grow faster than medical and nursing roles, but the relative increase has been greater than expected. Medical and nursing staff made up 40% of the workforce in 2021-22, down from 47% in 2011-12, while that for therapy staff increased from 12% to 18% over the same period. The profile has also shifted to more junior roles across different staff groups. The NHS will have to manage these changes carefully, given the reported increase in complexity and severity of problems for people accessing services. NHSE and HEE have developed more senior non-clinical roles, routes to progressing to clinical roles, and professional education and training to gain more clinical experience. These aim, in part, to develop experience, alongside supporting recruitment and increasing retention for this relatively large influx of these newer roles. In the longer term, while there are increases in the number of doctors choosing to specialise in psychiatry,[32] and general increases in nursing students,[33] it is difficult to say exactly how many of them will join the NHS mental health workforce, and when.

32 For the mental health workforce, the number of doctors in core training, and choosing to specialise in psychiatry, increased by 45% from 1,186 to 1,716 posts between 2012 and 2022. The number of doctors in higher speciality training increased by only 4%, from 1,689 to 1,751, with lower numbers between 2013 and 2021. As at August 2022, 99% of core psychiatric training posts were filled, comparing well with other specialisms. However, the proportion of higher speciality training posts filled was 83% across all psychiatric specialisms, lower than for GPs (100%) and other specialisms (94%).

33 Published figures from UCAS (the Universities and Colleges Admissions Service) indicate that the number of applications for mental health nursing rose between 2017 and 2021. In particular, 2020 applications were 36% higher than in 2019, and 2021 applications were 30% higher. The higher numbers of applications from 2020 would imply higher numbers of mental health nurse graduates might be available for recruitment from late 2023, assuming that these increases in applications result in similar increases in people starting nursing courses, and completing them. Also, while recent graduates are a major source of new nurses to the NHS, not all mental health nursing graduates will go on to work as nurses, or necessarily join the NHS or practise as a mental health nurse.

Figure 14

Trends in NHS mental health workforce indicators in England from 2011-12 to 2021-22

The number of staff in therapist and non-clinical roles has grown faster than in medical and nursing roles

Indicator	2011-12	2016-17	2021-22	Commentary
Staff mix:				
percentage medical and nursing staff of total	47%	45%	40%	Increase in proportion of therapists and other clinically qualified staff, and associated support staff.
percentage therapists and other clinically qualified staff of total	12%	16%	18%	
percentage support to therapists and other clinically qualified staff of total	5%	6%	11%	
Staff roles:				
percentage of medical staff who are core trainee doctors	6%	6%	8%	Increase in proportion of more junior roles, with the exception of nursing.
percentage of nursing staff who are band 5 (entry level)	19%	17%	11%	
percentage of therapists and other clinically qualified staff who are band 5 (entry level)	3%	4%	4%	
percentage of support to therapists and other clinically qualified staff who are bands 1–5	54%	66%	71%	
Joiners/leavers/turnover: (1st year relates to 2012-13)				
joiner rate	9%	13%	15%	Increase in joiner and leaver rates, with joiner rates now higher than leaver rates. Increase in the number of leavers in 2021-22.
leaver rate	10%	12%	12%	
number of leavers (000s)	13	15	17	
stability index	90%	88%	88%	
Reason for leaving: (1st year relates to 2012-13)				
percentage of reasons for leaving recorded as retirement	21%	20%	19%	Increase in proportion citing work-life balance reasons.
percentage of reasons for leaving recorded as work-life balance	4%	8%	14%	
Staff sickness absence:				
percentage of total full-time equivalent days lost to staff sickness	5%	5%	6%	Increase in reported absence due to poor mental health.
percentage of days lost that were due to psychiatric reasons	18%	27%	30%	
Demographic profile:				
percentage female staff of total	71%	73%	75%	Increase in proportion of female staff. Increase in proportion of minority ethnic staff. Increase in proportion of staff aged 55 and over.
percentage ethnic minority staff of total	19%	20%	24%	
percentage staff aged 55 and over of total	16%	18%	20%	

Figure 14 *continued*
Trends in NHS mental health workforce indicators in England from 2011-12 to 2021-22

Notes

1 All analyses based on staff in NHS mental health workforce, as defined by NHS Digital.

2 'Nursing staff' comprises the staff group nurses & health visitors, which includes a very small number (8 in 2022) of health visitor staff. 'Therapists and other clinically qualified staff' comprises the staff group scientific, therapeutic and technical staff. This primarily consists of therapists (in talking therapy or Improving Access to Psychological Therapies (IAPT) services) and scientists (which includes psychologists, psychotherapists and therapists in the mental health workforce, outside IAPT services). 'Support to therapists and other clinically qualified staff' comprises the staff group support to scientific, therapeutic and technical staff. This includes assistant psychologists, as well as new roles such as psychological wellbeing practitioners, mental health practitioners, and peer support workers.

3 For joiners/leavers/turnover and reason for leaving, 2012-13 data were analysed, rather than 2011-12. Analysis of reasons for leaving excludes unknown reasons. Analysis by ethnic group excludes don't know and not answered responses.

4 For staff mix, not all staff groups shown so total does not add up to 100%.

5 NHS Digital publishes data on joiner rates, leaver rates and stability index for the NHS workforce. Leaver (joiner) rates are calculated by dividing the number of leavers (joiners) for a category of staff by the average of the number of staff in that category at the beginning and end of the period. The stability index is the leaver numbers for the year divided by the headcount of staff at the start of the year subtracted from 1 and expressed as a percentage.

Source: National Audit Office analysis of NHS Digital data

Funding, spend and commissioning

Increasing the share of mental health funding and the Mental Health Investment Standard

3.7 NHSE has a general ambition to increase the share of funding for mental health services (see Figure 4 in Part One). Specifically, in 2015-16, it introduced the Mental Health Investment Standard (MHIS), which required clinical commissioning groups (CCGs) – and from 2022, ICBs – to increase their annual spend on mental health services, at a faster growth rate than their overall allocation. The MHIS does not set any minimum increase in spending and can therefore be met with a very small proportional increase.[34] In 2019, it also made a commitment that funding for children and young people's mental health services would grow faster than both overall NHS funding and total mental health spending.

34 The Mental Health Investment Standard is based on mental health spending by CCGs and ICBs, excluding NHSE spend on specialised commissioning. It also excludes spending on learning disabilities, autism and dementia services, as well as any (non-recurrent) transformation funding, used for mental health services.

3.8 The NHS reports that nationally it has met the MHIS since 2015-16 (**Figure 15** on pages 54 and 55): 100% of local areas met it individually in 2020-21 and 2021-22 (subject to independent review), and all ICBs were planning to meet it in 2022-23. Published NHSE data indicate that the proportion of CCG funding spent on mental health services, including spend on dementia, learning disability and autism services, increased year on year from 13.1% in 2015-16 to 14.8% in 2020-21, an increase of 1.7 percentage points. In 2021-22, the share of funding was 13.8%, although changes to baseline allocations meant the calculated share of funding was not comparable to previous years. We carried out further analysis on the share of funding to exclude spend on dementia, learning disability and autism services, in line with the MHIS definition. Our calculations suggest smaller increases in the share of funding: in particular, the share of funding changed little and even reduced in the years between 2016-17 and 2019-20, and only increased by 0.4% in total between 2016-17 (11.0%) and 2020-21 (11.4%).[35] The rate of increase in the share of funding is therefore very slow, reflecting the pace set by NHSE's target. Since 2018-19, the share of mental health services funding going to children and young people's services has increased.

3.9 NHSE has taken a proactive approach to monitoring the MHIS, improving the data available since 2015-16 and requiring local areas to commission independent audits of their spend data from 2018-19.[36] In our interviews with local NHS bodies and other stakeholders, many welcomed the focus that the MHIS had brought, but there were concerns that it did not address past under-funding, ensure money was spent locally on the right priorities within mental health, or provide full transparency over how much front-line provider spend had increased. From 2022, the Health and Social Care Act 2022 requires NHSE to disclose its annual spending in relation to mental health, including as a proportion of its total spending. The Department of Health & Social Care (DHSC) must also state whether it expects NHSE to increase the amount and proportion of spending on mental health compared to the previous financial year and why.

35 NHSE highlighted concerns over the quality of the data used for MHIS reporting, in particular during the earlier years, and its ongoing efforts to improve data quality, as noted in paragraph 3.9. Any change in data reporting may have affected the reported proportion of spend on mental health from year to year. For example, before 2018-19, one-off non-recurrent spending was included in MHIS reporting but was subsequently removed. To make the data more comparable, our calculation removes known non-recurrent CCG spend on mental health for 2016-17 and 2017-18. However, interpretation of the year-on-year changes in share of funding and MHIS-related spending needs to be viewed in this context.

36 From 2018-19, CCGs were required to commission independent reviews of their performance against the MHIS. For 2018-19 and 2019-20, these confirmed that the MHIS was met nationally, but that 16 CCGs (8%) in 2018-19 and 10 (5%) in 2019-20 did not meet the standard. The requirement was suspended in 2020-21 due to the COVID-19 pandemic, but resumed for ICBs from 2021-22. NHSE also issued detailed guidance to CCGs in 2020 on mental health spending categories, with local areas reclassifying spending where necessary.

Figure 15

Trends in performance against mental health spending targets, and financial health indicators for NHS mental health trusts, in England from 2015-16 to 2022-23

The NHS reports that nationally it has met the Mental Health Investment Standard (MHIS) since 2015-16

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23 (planned)
Total spend on mental health services – local plus NHS England (NHSE) spend (£mn)[1]	n/a	9,775	10,045	10,195	10,821	11,431	12,034	12,520
Total spend on children and young people's mental health services (£mn)[1]	n/a	515	687	774	853	932	995	1,081
Mental Health Investment Standard spending[2]								
MHIS met nationally and percentage of clinical commissioning groups (CCGs)/integrated care boards (ICBs) meeting MHIS individually[2]	Yes – 81%	Yes – 85%	Yes – 90%	Yes – 92%	Yes – 95%	Yes – 100%	Yes – 100%	Yes – 100%
Overall CCG/ICB spend counted for MHIS (£mn)[1]	n/a	7,896	8,148	8,241	8,764	9,210	9,707	10,350
CCG/ICB spend on mental health as percentage of overall allocations:								
• including spending on learning disabilities, autism and dementia (NHSE dashboard estimate); and	13.1%	13.6%	13.7%	13.8%	14.0%	14.8%	13.8%	13.8%
• excluding spending on learning disabilities, autism and dementia (National Audit Office estimate)	n/a	11.0%	11.1%	10.9%	11.0%	11.4%	10.5%	n/a
CCG/ICB spend on children and young people's mental health services as percentage of overall mental health spend[5]	Not calculated - NHS commitment in 2019 for funding for children and young people's mental health services to grow faster than total mental health spending			9.4%	9.7%	10.1%	10.2%	10.6%
Other spend and financial health indicators (based on mental health trusts, mental health and community service trusts, and integrated trusts)[5]								
Percentage of trusts in deficit[6]	n/a	11.5%	11.5%	11.5%	7.7%	9.6%	5.8%	n/a
Average surplus (for those in surplus) (£mn)[6]	n/a	9.1	6.8	9.3	3.7	1.6	1.9	n/a
Total operating expenditure (£mn)	11,163	11,020	11,581	12,356	13,727	15,945	17,885	n/a
Total capital investment required to eradicate backlog maintenance (£mn)[7]	300	268	356	370	547	743	855	n/a
Total capital expenditure (£mn)[8]	n/a	n/a	384	143	172	218	219	n/a
Total capital expenditure as percentage of backlog maintenance requirement[9]	n/a	n/a	107.7%	38.7%	31.5%	29.3%	25.6%	n/a

Figure 15 *continued*

Trends in performance against mental health spending targets, and financial health indicators for NHS mental health trusts, in England from 2015-16 to 2022-23

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23 (planned)
Average percentage of operating expenditure spent on:								
• agency/bank/contract staff; and	6.4%[9]	6.1%	4.6%	4.5%	4.5%	4.7%	5.5%	n/a
• purchase of healthcare from non-NHS bodies[10]	2.2%	2.6%	2.8%	3.0%	3.0%	3.7%	4.2%	n/a

Notes

1 For spend on mental health services, analysis is based on returns from local areas to NHS England's (NHSE's) internal monitoring and NHSE's published mental health services dashboard. For data up to 2021-22, the dashboard figures for local clinical commissioning groups (CCGs)/ integrated care boards (ICBs) include learning disabilities, dementia and autism but we have excluded this spending from our calculation using detailed CCG spend data submitted to NHSE. For 2022-23, figures are based on ICB plans submitted to NHSE plus planned national spending on mental health from NHSE 2022-23 Quarter 1 dashboard. The analysis did not include central transformation funding made available to CCGs/ICBs to support mental health service transformation. Spending by NHSE directly on specialised mental health services is not included in spending on mental health services by CCGs/ICBs. NHSE does not consider data before 2016-17 as reliable. It also considers that data for 2016-17 and 2017-18 may to some extent overstate spend compared to 2018-19 onwards, prior to local areas conducting independent reviews of their spend. To improve comparability, we have removed any known non-recurrent mental health spending by CCGs from our calculation of total spend on mental health services and total spend on children and young people's mental health service prior to 2018-19. We also applied this removal to our estimates of the CCG/ICB funding counted for the mental health investment standard (MHIS) and the share of CCG/ICB funding spent on mental health prior to 2018-19.

2 The MHIS required CCGs, and from 2022 ICBs, to increase their annual spend on mental health services at a faster growth rate than their overall allocation. For MHIS indicators, analysis is based on returns from local areas to NHSE's internal monitoring and published NHSE dashboards. MHIS met nationally and the proportion of CCGs/ICBs meeting MHIS individually is taken from NHSE's published mental health services dashboard. The dashboard CCG/ICB spending figures include learning disabilities, dementia and autism but we have excluded this spending from our calculation.

3 CCGs were in place up to July 2022, with 106 CCGs in England as of April 2022. From 1 July 2022, they were superseded by 42 ICBs.

4 In the data published by NHSE in its mental health dashboard, CCG/ICB spend on mental health as a percentage of their overall allocations also includes CCG spend on learning disabilities, dementia and autism as mental health spend. For the financial years where data are available, we also calculated the percentage of CCG/ICB spend on mental health excluding their spend on learning disabilities, dementia and autism. CCG/ICB spend on mental health as a percentage of their overall allocations appears to fall in 2021-22 due to an increase in the denominator used in the calculation. Prior to 2021-22, this was calculated against CCG core allocations which excluded provider deficit funding. From 2021-22, this deficit funding was put into CCG allocations. In 2022-23, the calculation is total ICB planned mental health service expenditure over total ICB planned expenditure.

5 For financial health and spend indicators, we include (a) NHS trusts solely providing mental health services and (b) combined or integrated trusts providing mental health services alongside community or acute services. For the second group, mental health services accounted for 59% of their income in 2021-22 both on average and in total. The list was provided to us by NHSE. We are aware that other trusts which are not included in our analysis may also provide some mental health services, but they usually account for a small proportion of their income. In 2021-22, there were 27 NHS trusts classed as mental health and 25 combined trusts included for these analyses; numbers in other years vary slightly due to mergers and reorganisations. For all other years, we only included trusts which are on the 2021-22 list. Unless otherwise stated, analysis is based on trust and CCG accounts, and ICB plans for 2022-23. For 2021-22, accounts for a small number of trusts and CCGs were not finalised at the time of our analysis but we do not anticipate meaningful changes to our analysis here when all accounts are finalised.

6 Deficit and surplus analysis is based on adjusted financial performance surplus/(deficit) from trust accounts. In 2015-16 this figure was not available in the accounts.

7 Capital investment required to eradicate backlog maintenance is taken from the Estates Returns Information Collection published by NHS Digital.

8 Total capital expenditure was not disclosed in the 2015-16 or 2016-17 trust accounts.

9 NHS Foundation trust accounts did not disclose their spend on bank staff in 2015-16. Our analysis therefore only includes spend on agency/contract staff for NHS trusts in that year.

10 Mental health service spend on non-NHS providers as a percentage of total mental health service spend includes spend on learning disabilities, dementia and autism by trusts. Non-NHS providers include voluntary and community sector providers, and independent providers.

Source: National Audit Office analysis of clinical commissioning group and trust accounts, internal NHS England financial monitoring information, integrated care board plans, NHS England published mental health dashboard data and NHS Digital published Estates Returns Information Collection data

3.10 We examined whether increases in spending were in line with past NHSE commitments on additional funding for mental health services.[37]

- To meet its ambitions on funding, NHSE estimated that overall annual mental health spending in 2023-24 would need to increase by at least £3.4 billion (£2.3 billion in real terms), compared with 2018-19. Our analysis of NHSE and accounts data up to 2021-22 suggested that, on the basis of national and local spend, it was on track to meet this overall ambition in cash terms. However, recent rises in inflation may reduce the amount of future funding increases in real terms.
- The government also made separate commitments on additional spend for children and young people's mental health services, equating to an additional £1,325 million for the period 2016-17 to 2020-21, or £265 million a year above 2015-16 spending levels.[38] However, there was no reliable baseline measure for 2015-16. Our analysis, taking NHSE's best estimate of around £515 million for 2015-16, suggests additional spend of around £1,345 million, a little higher than the original commitment.

Other financial and commissioning risks

3.11 Mental health trusts (in common with all NHS trusts) face a number of financial pressures in 2022-23, including managing the impact of higher inflation on pay and other costs, and the need to make savings as the system transitions from higher COVID-19 funding. However, our analysis of published accounts suggested that the financial health of NHS mental health trusts was generally better than for other NHS trusts, although mental health trusts had a higher, and increasing, level of spend on temporary and bank staff. We heard from stakeholders that historically mental health trusts have had more latitude to vary service provision, to deal with funding or staffing constraints, and maintain their financial position.

37 In 2021-22, the government also provided additional funding of £500 million for mental health services recovery following the COVID-19 pandemic.

38 This included £150 million for eating disorder services for children and young people, with a further £75 million committed for perinatal services. In our 2018 report on children and young people's mental health services, we found that NHSE could not be certain all the additional £1.4 billion funding to date was spent as intended, particularly prior to 2017-18. We found that NHSE had improved its monitoring of funding, with more assurance that funding by service area was correctly categorised.

3.12 We identified a number of funding and commissioning issues that NHS mental health trusts and the broader mental health sector will need to address.

- **Under-funding and lack of information on costs of services.** Despite recent growth in funding to cover specific commitments to expand services, in our surveys, 28 out of 34 trusts, and 24 out of 29 ICBs, said historical under-funding of mental health services was a significant barrier to efforts to improve services. However, only five out of 29 ICBs in our survey said they had all or most of the data they needed to assess actual costs of providing services. This lack of data may be linked to the widespread use of block contracts for mental health services up to 2021-22, where payment is not linked directly to actual activity levels.[39]

- **Simplifying commissioning arrangements.** In our stakeholder interviews, we heard that commissioning for mental health services was overly complex and fragmented, with multiple commissioners, service specifications and approaches for different localities and services. In our survey of mental health trusts, 20 out of 34 said complex or uncoordinated contracting arrangements were a significant barrier to service improvement. Mental health also tends to have higher levels of contracting to non-NHS providers. In our ICB survey, 19 out of 28 said that use of short-term contracts for voluntary and community sector providers was a significant barrier to service improvement. Our interviews with stakeholders highlighted the importance of such contracts, and the need to improve contracting approaches.

- **Capital requirements.** Although, compared with other trusts, NHS mental health trusts tend to have lower capital requirements, the amount required to address backlog maintenance increased sharply between 2018-19 and 2021-22, compared with a slight rise in trusts' capital spend (Figure 15). As of 2022, the main programmes of capital investment for mental health services focus on replacing inpatient dormitories with single-room accommodation, and improving urgent and emergency care settings. NHSE told us its future priorities would be upgrading inpatient settings, and community mental health service facilities (see paragraph 2.16). However, on current trends for mental health trusts, the gap between spending and what is needed for even basic maintenance of the estate is widening (Figure 15).

39 In 2021-22, 82% of trust mental health income came through block contracts. From 2021-22, NHSE introduced an 'aligned payment and incentive approach' for most trust services, including mental health services. This is based on blended payments, comprising a majority fixed element, plus a variable element, which may depend on, for example, activity or performance.

Data and information on mental health services

3.13 Compared with general acute NHS services, historically there has been a lack of data on mental health services. From 2003, NHS Digital started publishing experimental data on NHS mental health services for people with long-term mental health conditions. Since 2016, NHSE, working with NHS Digital and Public Health England (now the Office for Health Improvement and Disparities), has invested in a number of new and existing datasets (**Figure 16** on pages 59 and 60). A particular focus has been on the Mental Health Services Data Set (MHSDS), which brings together data on services provided in the community, hospitals and outpatient clinics, as well as developing data on the prevalence of mental ill health, costs of services provided, and user outcomes and experiences.

3.14 Information on mental health services has improved, albeit from a low point. There is now regularly published information available on trends and variations in service activity and performance against the new standards, spending by local bodies on mental health services, and information on mental health inequalities.

3.15 However, the national programme consistently rates 'data and information' as one of two 'red' risks, with progress in developing mental health datasets behind plans in many areas. Many of the datasets that are important for managing and developing services and measuring improvement, including access to services and costs, still lack the required completeness and quality (Figure 16). For example, for the core MHSDS, which NHSE relies on for monitoring progress in access to services and performance against services standards, all providers were expected to submit to MHSDS by 2020-21. The number of providers submitting data has increased from 85 in 2016 to 364 in June 2022. But as at June 2022, 5% of NHS providers and up to 33% of non-NHS providers identified by NHS Digital were not submitting data to MHSDS.[40] The slower progress with MHSDS has resulted in the continued duplication of data collection for a number of indicators.

3.16 In addition to less developed data on patient outcomes (see paragraph 2.20), there are also concerns about a lack of quality data on the cost of services provided. NHSE told us that all but two designated NHS mental health trusts are now submitting patient level cost information, but it is not yet able to confirm the quality of the data collected. In our survey of ICBs, 16 out of 28 considered a lack of robust data on costs for services commissioned as a significant barrier in their efforts to improve services.

40 In June 2022, NHS Digital identified 539 providers for potential data submission. For 22 providers, their organisation type is unknown and we have included them as non-NHS providers. Not all organisations identified by NHS Digital as potential providers for data submissions will need to submit data as some may not provide NHS-funded services during the reporting period. The number of potential providers fluctuates from month to month.

Figure 16

Overview of progress to date for data on NHS mental health services in England and National Audit Office (NAO) assessment of main risks and concerns

Data on NHS mental health services have significantly improved but data quality and completeness remain a concern, and there is still a lack of data on patient outcomes

Data areas	Progress to date	NAO assessment of risks and concerns
Prevalence and incidence	NHS Digital planned prevalence surveys for children and adults every seven years. Last adult survey in 2014. Fieldwork for next adult survey due to start in 2023, with reporting in 2024-25. Last main survey for children and young people in 2017, with follow-ups conducted during the COVID-19 pandemic in 2020, 2021 and 2022. The Office for Health Improvement and Disparities publishes routine surveillance on mental health using indicators from the Office for National Statistics and other research bodies.	Lack of breakdown by population groups including ethnicity and deprivation. Lack of timeliness for adult prevalence.
Service performance, activity, access, and quality, including performance against the new access and waiting time standards	The Mental Health Services Data Set (MHSDS) has been established, which now covers many mental health services, alongside the data set for Improving Access to Psychological Therapies (IAPT) services. Data are collected and published for most of *The NHS Long Term Plan* commitments for key service areas on access and waiting times including monthly, quarterly or annual publications. For some service areas and indicators, such as children and young people's eating disorder services and out of area placements, data quality issues in the MHSDS mean bespoke data collections are still required.	Lack of completion by providers: in June 2022, 5% of NHS providers and up to 33% of non-NHS providers were not submitting data. Concerns over the quality, consistency and completeness of data submitted. The percentage of records submitted that are valid was 50% in September 2022. 23% of the records are considered either as invalid, lacking data integrity or missing. The percentage of data submitted as unknown increased from 15% in April 2021 to 21%. For some data fields on protected characteristics, only a small proportion of submissions are considered as accurate, eg in September 2022, 14% for religion and 11% for sexuality. Data quality affected monitoring of some important commitments, including (as at May 2022) the number of young people aged 0–25 accessing services, and milestones related to the improvement of community mental health services. Risk of provider burden and potential duplication from additional data collections. As at February 2023, there were bespoke collections for out of area placements, and children and young people's eating disorder services (planned to stop in March 2023).

Figure 16 *continued*
Overview of progress to date for data on NHS mental health services in England and National Audit Office (NAO) assessment of main risks and concerns

Data areas	Progress to date	NAO assessment of risks and concerns
User outcomes and experiences	Framework for outcome measures in development. Recovery rates for IAPT collected and published on a routine basis including more detailed breakdowns by intervention types. Experiences of people who use community mental health services published annually.	Lack of completion by providers, with some regions currently reporting below 20% for service outcomes. For children and young people aged under 18, NHS Digital could only pair 19.5% of patients with outcomes scores as at the end of December 2021. NHS England (NHSE) planned to report on the mental health outcomes for children and young people (measurable change in symptoms and functioning) nationally from 2020-21 but as at June 2022, only 38% of the data required were submitted.
Finance (cost and spending)	All NHS providers are required to provide patient-level costing information (PLICS). NHSE routinely collects local area spending on mental health services, broken down by the main service areas, including information published in NHSE's Mental Health Dashboard.	45 out of 47 trusts submitted PLICS data in 2021-22. Although all trusts passed validation checks required for submission, NHSE has not yet reviewed the 2021-22 data in order to provide final assurance on them. Spending data on different service areas still lack granularity. Understanding of costs of services is still poor for many areas, including in primary and community services.
Mental health inequalities	Variations in access by geographical area and demographic breakdowns published on a regular basis for a number of metrics for some specific service areas. For example, regional and age breakdowns for IAPT services, and children and young people's services have been published since 2021-22, and there are regular updates on premature mortality of people with severe mental illnesses. NHS Digital published equality data guidance in 2022 to support data collection and the Office for Health Improvement and Disparities now publishes indicators on disparities in access to services by gender, age, ethnicity and deprivation.	Lack of direct measure of variation in outcomes for most of the service areas except for IAPT recovery rates. Incomplete or poor quality data for some protected characteristics (see above for MHSDS).

Note

1 In June 2022, NHS Digital identified 539 providers for potential data submission. For 22 providers, their organisation type is unknown and we have included them as non-NHS providers. Not all organisations identified by NHS Digital as potential providers for data submissions will need to submit data as some may not provide NHS-funded services during the reporting period. The number of potential providers fluctuates from month to month.

Source: National Audit Office review of NHS England and NHS Digital documentation

Future demand for mental health services

3.17 Demand for mental health services is likely to be higher than what was anticipated in the LTP, including as a result of the COVID-19 pandemic.

- There have been particular surges in demand among younger people: between 2017 and 2022, the rates of probable mental disorders increased from 12% to 18% for 7- to 16-year-olds and from 10% to 26% for 17- to 19-year-olds.
- Among adults, it is difficult to predict future post-pandemic demand as the most recent data are from 2014. New prevalence data for adults are due to be published in 2024-25. Surveys carried out by the Office for National Statistics indicated that common mental health issues have increased among adults following the pandemic: 17% of adults surveyed experienced moderate to severe depressive symptoms in 2022, compared to 10% before the pandemic. DHSC recognises that there may be further increases in mental health disorders among adults as the economic situation worsens following the pandemic.

3.18 The original improvement trajectories meant that by 2023-24 only a minority of people with mental health needs overall would receive treatment (see paragraphs 1.15 to 1.17). Any increase in prevalence means that it will take longer to reduce the treatment gap, or the gap could increase. As noted in paragraph 2.11, there are also signs that the complexity and severity of people's conditions are increasing, which may necessitate more, or more intensive treatments.

3.19 Telephone and online provision of mental health services, which was important during the pandemic, may play a greater part in future services. Between 2019-20 and 2021-22, for example, the proportion of talking therapy sessions conducted over the telephone increased from 21% to 60%, and by video from 2% to 26%. For 2022-23, NHSE told us that it was encouraging a return to face-to-face sessions where patients wanted it. Its broader evidence on remote delivery suggests that it will be important to:

- support patient choice, as how well online/telephone provision works varies greatly for reasons including individual preferences, medical conditions, access and ability to use technology, and home environment;
- consider online/telephone provision alongside face-to-face services, rather than as a replacement, to support more flexible, person-centred care; and
- train staff, and provide support for patients and staff to access and use technology effectively and safely.

Appendix One

Our evidence base

1 Our conclusion on whether the government achieved value for money in its work to expand and improve NHS-funded mental health services and the progress made towards the long-term goal of parity of esteem between physical and mental health services was reached by analysing evidence collected between March and December 2022.

2 The analytical framework underpinning our conclusions considered whether the Department of Health & Social Care (DHSC) and NHS England (NHSE), working with NHS Digital and Health Education England (HEE), had a clear understanding of how their efforts to date contributed to closing the gap between mental and physical health services, and what they needed to put in place to achieve that; whether the NHS met ambitions to increase access, capacity, workforce and funding for mental health services; and whether DHSC and NHSE are well placed to make further progress towards parity of esteem and overcome future risks and challenges.

3 The ambitions for mental health services were wide-ranging. This report focuses on commitments to: increase service capacity and activity, and implement new access and waiting time standards; improve community mental health care; increase the mental health workforce; increase funding for mental health services; and improve data. The scope excludes services for dementia, learning disabilities and autism, and substance abuse services. It also excludes preventive services for mental health, and the provision of assessments carried out under the Mental Health Act. The report does not investigate clinical safety and quality of NHS mental health services in depth, including the use of restraint and seclusion.

Interviews

4 We conducted more than 50 virtual semi-structured interviews with representatives from DHSC, NHSE, NHS Digital and HEE, other government bodies, and wider stakeholders to inform our audit.

- **DHSC and NHSE:** we interviewed officials from DHSC and NHSE to gain an understanding of mental health policy, and the progress made and challenges in implementing mental health policies, including governance arrangements, finance, workforce issues, inequalities and the impact of the COVID-19 pandemic. We held regular meetings with the relevant national DHSC and NHSE mental health teams and spoke to three regional NHSE teams. We also spoke to three NHS trusts providing mental health services at the start of the study, to understand the local provision of mental health services and the main challenges in delivery. The trusts were: Central North West London NHS Trust, Greater Manchester Mental Health NHS Foundation Trust, and Tees, Esk and Wear Valley NHS Foundation Trust.

- **HEE and NHS Digital:** we interviewed officials from HEE to understand issues, and actions it had taken, in workforce planning, recruitment, retention, education and training. We met with NHS Digital to understand issues, and actions it had taken, with respect to improving data and information for mental health services. We held regular meetings with HEE and NHS Digital during fieldwork. NHS Digital merged with NHSE on 1 February before the publication of this report. However, throughout our fieldwork, NHS Digital worked with us as a separate body and we have kept references to NHS Digital for all the data, documentation and other evidence provided by NHS Digital to us in this report.

- **Other national government bodies:** we interviewed officials from other government bodies to understand their roles, responsibilities and working relationships with NHSE and other stakeholders in the delivery of mental health services. We met with the Care Quality Commission, the Office for Health Improvement and Disparities, the Department for Levelling Up, Housing & Communities, and the Department for Education.

- **Wider stakeholders:** we interviewed representatives from mental health stakeholder organisations to understand their views on the progress against, and main challenges to, ambitions to improve NHS services. We met with the Association of Directors of Adult Social Services, Association of Mental Health Providers, the British Medical Association, the British Psychological Society, Centre for Mental Health, Cygnet Health Care, Healthcare Financial Management Association, HealthWatch, Independent Healthcare Providers Network, The King's Fund, Local Government Association, MIND, the Mental Health Foundation, the NHS Confederation, NHS Providers, Nuffield Trust, Nursing and Midwifery Council, Royal College of Nursing, Royal College of Psychiatrists and Rethink Mental Health.

Document review

5 We reviewed more than 650 published and unpublished documents, of which around 600 were provided by DHSC, NHSE, NHS Digital and HEE. These included board papers and minutes, ministerial submissions, business cases and bids for funding, policy papers, internal planning documents, guidance and communications for local systems and providers, case studies and good practice guides, evaluations and other reports. We reviewed all documents against a framework reflecting the main evaluative areas set out in paragraph 5.

Surveys

6 We sent out an online survey to integrated care board (ICB) mental health leads, and NHS mental health trust chief executives, inviting senior representatives to respond. Survey questions covered views on: the future role of ICBs in improving mental health services (ICB survey only); national support and guidance; barriers and facilitators to service improvement, including workforce and funding; data quality and availability (ICBs); how well established pathways were between services; actions taken to manage service and demand pressures (trusts); and future national and local priorities.

7 We consulted with National Audit Office (NAO) survey specialists during the survey's planning. We tested the questions with a small number of local trusts and ICBs, provider representatives and audited bodies. The survey ran from September to October 2022. We received responses covering 28 ICBs (67% response rate), including three partial responses, and 39 trusts (74% response rate), including seven partial responses. We conducted virtual follow-up interviews with six trusts and four ICBs to ensure that we understood the survey findings.

Financial analysis

8 We analysed a range of financial information to understand spending on NHS mental health services overall and for different service areas, the effectiveness of the Mental Health Investment Standard and the financial health of NHS mental health trusts. The main sources included: published accounts for NHS trusts and clinical commissioning groups (CCGs); internal financial information collected by NHS England from CCGs; and ICB financial plans.

Quantitative analysis of non-financial data

9 We analysed national trend data across a range of metrics and indicators to understand demand for NHS mental health services, activity, performance against access and waiting times standards, indicators of stress, patient experiences and outcomes, workforce and vacancies. Where available, we examined variations in access, experiences and outcomes between different demographic and regional groups. Below we set out the main data sources that we used.

- Published NHS Digital data on overall NHS mental health services, improving access to psychological therapy (IAPT) services, early intervention in psychosis services, children and young people's mental health services, NHS workforce statistics and NHS vacancy statistics.
- Published NHSE data from the NHS mental health dashboard and for children and young people's eating disorder services and out of area placements.
- Further data requests to NHS Digital on the mental health sector workforce.
- Survey information on the prevalence of mental health disorders, published by NHS Digital.
- Care Quality Commission surveys of patient experiences, and ratings of mental health trusts.

Good practice in programme management

10 To support our evaluation, we assessed the national NHSE-led Mental Health Programme against a framework derived from previous NAO work on major projects and programmes. This allows us to focus on factors that we have identified as critical to the successful delivery of programmes.

CORRECTION SLIP

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Correction One:

In Figure 6, on page 30, under 'Crisis and liaison' sub-heading we mention '59% sustainability and transformation partnership (STP) coverage of liaison mental health teams' 59% is incorrect and should be 100%.

The entry should read:

100% sustainability and transformation partnership (STP) coverage of liaison mental health teams.

BACK

Date of correction: 7 February 2023

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