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Progress in improving NHS mental health services

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Summary

Currently, only around one in three people with a mental health need access mental health services, and an estimated 1.2 million people are on the waiting list for community mental health services. From a low base, NHS England (NHSE) has made progress in improving and expanding NHS mental health services over the last five years, particularly in treating more people and setting access standards and the number of people treated by NHS mental health services has substantially increased. However, many problems persist, and there is still much to tackle.

Rising demand for mental health services—particularly among young people, which has more than doubled since 2017—continues to outstrip service provision. The NHS mental health workforce increased by more than 22% between 2016–17 and 2021–22, but staff shortages remain the main threat to further improvement and expansion. Data and information for NHS mental health services—which are vital for managing performance, developing new services and addressing inequalities—also still lag behind that available for physical health services.

Many stakeholders have welcomed the introduction of new access targets and waiting times standards for mental health services, with better performance seen against some of these. However, the standards only cover a minority of people who are referred to mental health services and, despite defining further standards more than a year ago, there are still no plans to roll these out. All this means people are still not be getting the mental health treatment they need when they need it, and places strains on patients, staff and service quality.

In 2011, the government set out its goal of achieving "parity of esteem" between mental and physical health services without setting out what achieving it meant in practical terms. In 2019, when we reported on children and young people's mental health services, we highlighted the need for the government to define "parity of esteem" clearly, including setting out the criteria it will use to measure progress. The government accepted our recommendation but disappointingly it has still not done so. This is despite NHSE telling us that it would welcome a definition of 'parity of esteem', which could encompass parity in funding, waiting times and outcomes, as well as the provision of data and information on services. With the NHS focusing on reducing backlogs for physical health services, we have concerns about how committed national and local NHS bodies and the new integrated care systems are to keeping mental health services and support high up the agenda. In addition, the government has made little progress in improving preventive and public health services for mental health alongside NHS treatment services, despite this being envisaged in its original strategies.

Introduction

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. People with mental health conditions often have poorer physical health, education and housing, so it is vital they are able to access the services and support that they need.

The Department of Health & Social Care (the Department) is responsible for mental health policy. NHS England (NHSE) oversees the commissioning of NHS-funded services, with most services commissioned locally by integrated care boards (ICBs), which replaced clinical commissioning groups (CCGs) in 2022. In 2021–22, the NHS spent £12.0 billion on mental health services, around 9% of its total budget. In 2011, the government acknowledged a large treatment gap for people with mental health conditions and sought to establish 'parity of esteem' between mental and physical health services. From 2016, the Department and NHSE made specific commitments to improve and expand NHS-funded mental health services. NHSE, working with the Department and other national health bodies, set up and led a national improvement programme to deliver these commitments.

Conclusions and recommendations

1. **Workforce shortages are constraining the improvement and expansion of NHS mental health services.** Over the period 2016–17 to 2021–22, the NHS mental health workforce increased by 22% overall, although the increase varied greatly for different staff groups – higher for therapists and lower for doctors and nurses. Over the same period, referrals to the services increased by 44%, meaning that the increase in staff was outpaced by the rise in demand for services. The number of people with mental health needs is also increasing, for example, the proportion of 17–19-year-olds with a probable mental disorder more than doubled from 10% in 2017 to 26% in 2022. The Department and NHSE acknowledge that staff shortages remain the main constraint to improving and expanding services. We are also concerned about increasing pressures on staff, as evidenced by the rising number of staff sick days due to poor mental health and number of staff leaving. NHSE is taking short-term measures to try and help increase staff numbers, for example, through the introduction of new roles. For the longer term, NHSE emphasises the importance of continued funding for education and training pipelines as the current arrangements end by 2023–24. Given the immense challenges facing the workforce, we have been particularly concerned by the absence of the NHS's long term workforce plan, which was eventually published on 30 June 2023. The plan predicts that demand for mental health services will grow faster than for other NHS services and confirms the particular challenge of expanding the mental health workforce.

   Recommendation 1: ***In six months' time, NHS England should write to the Committee setting out what targeted interventions are envisaged for the mental health sector under the plan to ensure it can get the doctors, nurses, therapists and other clinical and non-clinical staff that the service needs, and who will be responsible for delivering them.***

2. **Data and information for NHS mental health services still lags behind that for physical services.** Service commissioners and providers need good data and information to manage and improve services, and this is also important to understand the impact and cost-effectiveness of services. Data on NHS mental health services have improved since 2015, and the NHS now regularly publishes data on service activity, spending and waiting times performance. But improvements to mental health data and information are taking longer than planned, with many service providers still not submitting data as required. The Department and NHSE acknowledge that data for mental health services still lag behind that for physical health. We are particularly concerned by the lack of data on patient outcomes and experiences, and poor data sharing, for example, between GPs and mental health trusts. Of 29 integrated care boards surveyed by the NAO, only four 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. When asked about the relative value for money and returns on investment, the Department and NHSE could not explain to us the cost effectiveness of their chosen interventions for mental health services.

   Recommendation 2: ***In six months' time the Department and NHS England should write to the Committee, setting out how they will:***

- ***improve the quality and completeness of the data on mental health services, including cost of services and patient outcomes;***
- ***ensure these data are shared appropriately to support integrated care systems to improve services locally, including tackling inequalities; and***
- ***improve the evidence base on the cost-effectiveness of their investments, for example, on the roll out of mental health support teams in schools.***

3. **New integrated care boards and partnerships could struggle to prioritise mental health services and support, in the face of funding pressures and the need to reduce backlogs for physical health services.** ICBs will be responsible for bringing forward many of the ambitious programmes for mental health services in their area, for example, ensuring data sharing across local NHS, local government and voluntary sector organisations, and workforce planning and deployment. Many of the challenges that ICBs have to address involve longstanding and unresolved issues and as the Department itself notes, "the proof will be in the pudding". But we remain unconvinced that many of the ICBs, at this stage of their development, have the maturity, resources or capacity required to meet the high expectations placed on them for mental health services. This is particularly the case as ICBs tackle reducing backlogs for physical health services while under funding pressures. We are also concerned about the ability of NHSE, during a period of significant reorganisation, including a 30–40% planned reduction of central staffing, to support ICBs, hold them to account for performance, and challenge inconsistencies in local practices such as the patchy implementation of clinical guidance across local areas for people with eating disorders.

   Recommendation 3: ***NHS England and the Department should evaluate how well the new integrated care boards and partnerships are supporting mental health services and how well their own support arrangements work to address variation between, and poorer performance in, local areas.***

4. **There is still no clear definition of the end goal of 'parity of esteem' 12 years after the government first set out its ambitions.** From 2011, the government set out long-term ambitions to improve support and services for people with mental health problems and achieve 'parity of esteem' between mental health and physical health services. While the number of people accessing NHS funded mental services substantially increased from 3.6 million in 2016–17 to 4.5 million in 2021–22, as reported by the NAO, this still only equates to around one third of people with mental health needs, with an estimated eight million not accessing services. NHSE acknowledges that sizable treatment gaps will persist under the current planned rates of service expansion set for 2023–24. In our January 2019 report on mental health services for children and young people, we recommended that the Department should define clearly the criteria it would use to measure progress towards 'parity of esteem'—a recommendation accepted by government—and so are particularly concerned that there is still no detailed definition. Many stakeholders told us that a clear definition, objectives and roadmap are important to understand progress towards this end goal. NHSE would also welcome a definition, but the Department's current position is not to specify one.

Recommendation 4: ***In its update to us in six months, the Department should also set out what achieving full 'parity of esteem' between mental and physical health services means in practice, for example, comprehensive access and waiting times standards and outcomes, timescales, funding and workforce requirements.***

5. **The Department and NHS England have still not committed to rolling out waiting times standards to all mental health services.** From 2015, NHSE introduced specific waiting times standards for three service areas – talking therapy services, early intervention in psychosis services and eating disorder services for children and young people. Unlike the standards for physical health services, the current standards for mental health only apply to a limited number of service areas; they do not cover the bulk of core community and inpatient mental health services. In 2022, NHSE consulted on new waiting times standards for mental health services in the community and A&E, but it has not confirmed whether and when these will be implemented. NHSE says it has been improving data collection in preparation for the new standards over the last few years, but that is yet to agree with the Government on "trajectories for working towards meeting those standards". Stakeholders we spoke to argued that the introduction of new standards would also provide the much needed impetus for providers to improve data, and so poor data was not a reason to delay standards being introduced.

Recommendation 5: ***In its update to us in six months, the Department and NHS England should set out their plan for implementing the new service standards.***

6. **Preventive and public health services for mental health have not had the same priority and focus on improvement as NHS mental health treatment services.** Previous government strategies have emphasised the importance of preventive services for mental health and wellbeing, alongside treatment for mental illness. However, we, and many stakeholders, are concerned that preventive services have not been given the same priority and focus as NHS treatment services. From 2018–19 to 2022–23, the local authority public health grant had a real-terms reduction of 6%. The new ICSs will be a key mechanism for taking forward public health improvements and, while the Department and NHSE argue that "a fair amount of progress" has been made in promoting mental health over the last 10 to 15 years, they acknowledge that not all areas are fully mature in terms of preventive infrastructure. Given the range of social and economic factors that affect mental health, an effective preventive programme will require action from across government. In April 2022, government consulted on plans for a new 10-year cross-government strategy on mental health and wellbeing. However, many stakeholders have expressed their disappointment about the replacement of this by a planned five-year major conditions strategy from the Department, with mental health one of six conditions covered.

Recommendation 6: ***The Major Conditions Strategy must clearly set out how preventive and public health services for mental health will be improved and expanded, including how the right workforce will be secured.***

1 Progress in improving and expanding mental health services

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department) and NHS England (NHSE).[1] We also took evidence from the Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQC), Centre for Mental Health and Royal College of General Practitioners (RCGP).

2. 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. In 2017, the proportion of young people with a probable mental disorder was estimated at 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.[2]

3. The Department is responsible for mental health policy. NHSE oversees the commissioning of NHS-funded services. The Department and NHSE provide oversight, assurance and support for mental health services.[3] In 2021–22, the NHS spent £12 billion on mental health services in England, around 9% of the total NHS budget, with most mental health services (£9.7 billion in 2021–22) commissioned locally by CCGs (replaced by integrated care boards (ICBs) in July 2022) and the remainder commissioned centrally by NHSE. The NHS directly provides a wide range of mental health services and also commissions services from non-NHS (independent, voluntary and charity sector) providers.[4]

4. From 2016, the Department and NHSE made specific commitments to improve and expand NHS-funded mental health services. This included introducing waiting times standards for some mental health services for the first time, for example, talking therapy services, alongside a range of access targets, for example, 66,000 women to access specialist community perinatal mental health care by 2023–24. NHSE, working with the Department and other national health bodies, set up and led a national improvement programme to deliver these commitments.[5]

Workforce

5. From 2016–17 to 2021–22, the NHS mental health workforce increased by 22% to 133,000 full-time equivalent staff. This is, as the Department stressed, faster than the overall rate of growth for other NHS service areas over the same period. But the increase varied by staff group, for example, it was higher for therapists (41% increase against an

1 C&AG's Report, Progress in improving mental health services in England, Session 2022–23, HC 1082, 9 February 2023
2 C&AG's Report, paras 2, 1.3
3 C&AG's Report, paras 3 and 1.6. At the time of the C&AG's Report, Health Education England and NHS Digital were in existence as separate arm's length bodies, but these have now been merged into NHS England
4 C&AG's Report, paras 1.6–1.7
5 C&AG's Report, para 2 and Figure 4.

estimated requirement of 21%) and lower for doctors and nurses (for nurses, a 9% increase against an estimated requirement of 16%). The Department told us that vacancy rates in acute inpatient mental health services are "up to and around 20% plus".[6]

6. The Department and NHSE acknowledged that, despite the substantial increase in the mental health workforce, staff shortages remain the main constraint to improving and expanding services, and therefore the NHS's ability to reduce treatment gaps. Over the period 2016–17 to 2021–22, the rise in demand for services was greater than the increase in workforce (44% increase in activity, as measured by referrals to NHS mental health services, compared with a 22% increase in the NHS mental health workforce).[7] The number of people with mental health issues has continued to rise since the pandemic: for example, the proportion of 17–19 year olds with a probable mental disorder more than doubled from 10% in 2017 to 26% in 2022.[8]

7. We were also concerned about the impact of staff shortages on the welfare of the mental health workforce. Stakeholders told us about increased workload and pressure leading to "burnout" of remaining staff, contributing to a higher rate of staff turnover, and therefore more staff shortages in a vicious cycle. 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%) a year. The proportion of staff citing work-life balance reasons for leaving increased from 4% in 2012–13 to 14% in 2021–22. In addition, the percentage of days lost from the mental health workforce "due to psychiatric reasons" has doubled in a decade.[9] NHSE noted that, in common with all NHS staff, mental health problems are one of the two "biggest drivers of sickness". It told us it is "very sighted of" the issue and has been working with providers to help support staff wellbeing.[10] The Department and NHSE set out a number of other actions they are taking to help expand the workforce in the short term. These included, for example, schemes to increase overseas recruitment, the introduction of new additional roles such as peer support workers, the additional roles reimbursement scheme for GP practices to employ staff like mental health practitioners, and higher grants for mental health nursing students.[11]

8. The National Audit Office (NAO) reported that 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 the NHS estimated it needed for mental health. For the longer term, NHSE emphasised the importance of continued funding for training pipelines as current funding arrangements will end by 2023–24. We have also expressed concern about the absence of a long term workforce plan and tensions about funding. NHSE finally published the plan on 30 June 2023.[12] The plan sets out overall ambitions for the NHS to secure the staff it needs over the next 15 years, by increasing training pipelines, improving staff retention, and reforming the way staff work and train. It also estimates that mental health and learning disability services will see the highest growth in demand, and notes specific challenges in developing the required mental health workforce, including a higher than average shortfall of mental health nurses

6 Qq 46,79,91; C&AG's Report, para 13 and Figure 16
7 Qq 79–82; C&AG's Report, para 13
8 Qq 36, 52,182 ; C&AG's Report, paras 2.2, 3.17
9 Qq 40, 177; C&AG's Report, para 3.6 and Figure 14; PMS0006, page 7; PMS0011, page 5; PMS0008, pages 2–3
10 Qq 177–179
11 Qq 82, 85–87, 122, 146, 154; C&AG's Report, para 3.4
12 Qq 96, 135, 156, 167; C&AG's Report, para 3.5; NHS England, NHS Long Term Workforce Plan, June 2023

without additional interventions.[13] We also raised concerns about the lack of clarity in roles and responsibilities following the merger of NHSE and Health Education England. The Department assured us that there will be continued transparency about funding for education and training following the merger.[14]

Data and information

9. It is important to have the right data in place for mental health service commissioners and providers to manage and improve services, and to understand the cost effectiveness and impact of services, including patient experiences and outcomes.[15] We highlighted data gaps for mental health services in our 2016 report Improving access to mental health services and recommended the Department and NHS take action, by 2018–19, to improve data on cost and performance, including data on service outcomes.[16] Data on NHS mental health services have improved since 2015, with the NHS now regularly publishing data on service activity, spending and waiting time performance. However, improvements to mental health service data and information are taking longer than planned. For example, many service providers are still not submitting data as required. While the number of providers submitting data increased from 85 in 2016 to 364 in 2022, 5% of NHS providers and up to 33% of non-NHS providers were still not doing so by June 2022.[17] NHSE explained that, unlike other parts of the health service, a particular challenge to data collection for mental health services is that more services are provided by third-sector organisations which often have lesser infrastructure in place.[18]

10. Compared to physical health services, data for mental health services are less comprehensive and granular. The Department and NHSE acknowledged that data for mental health services still lag behind that for physical health services, but argued that they have taken "powerful" measures. For example, the Department and NHSE told us that, historically, the use of block contracts for mental health services was a disincentive to collecting cost data, but that they have shifted towards more of an activity-based payment system for mental health.[19]

11. There is a continuing lack of robust data on patient outcomes and experiences for most mental health services. Of the 29 integrated care boards surveyed by the NAO, only four 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. The Department stressed to us that outcomes data for talking therapies—recovery rates—are collected. NHSE agreed with us on the need for more progress and assured us that it has "a big program of work in place" this year to improve outcome measurements, including patient reported outcome measures.[20]

12. When we asked what criteria it used to decide on investment in one area against another, NHSE explained the consultative approach it took to prioritise services but could

13 NHS Long Term Workforce Plan, Overview, Chapter 1, paragraph 26, and Table 5
14 Qq 147–148
15 Qq 31,102, 105, 108, 111
16 House of Commons Committee of Public Accounts report, Improving access to mental health services, Sixteenth report of session 2016–17
17 Q 17; C&AG's Report, paras 7, 15
18 Q 102
19 Qq 101, 109–110; C&AG's Report, paras 7, 3.12.
20 Qq 34, 61, 98–105, 117; C&AG's Report, paras 15, 2.25

not explain to us the cost effectiveness of its chosen interventions. It agreed with us that it is important to understand the impact of its initiatives, highlighting the opportunity that its current evaluation of mental health support teams in schools provides to understand the impact of earlier interventions on preventing later problems.[21]

13. Stakeholders stressed to us the particular importance of coordinated care for people suffering ill mental health.[22] However, they were frustrated with difficulties in accessing and sharing data across different organisations, including between national and local bodies, and between health and social care sectors. For example, the vice-chair for external affairs for the RCGP, herself a practising GP, told us she could access patients' records from her local acute health trust, but not from the local mental health trust.[23] NHSE agreed that improving data sharing is a priority. It told us that it is looking to integrated care systems to make progress on this, but could not provide us with a time frame for the improvement it expects.[24]

Waiting times standards

14. From 2015, NHSE introduced specific waiting times standards for three service areas —talking therapy services, early intervention in psychosis services and eating disorder services for children and young people—which set ambitions for people to enter treatment quickly. While the NHS has met the standards for talking therapy services and early intervention in psychosis services, it has not yet done so for eating disorder services for children and young people.[25]

15. We are concerned about the NHS still not meeting the eating disorder service standards, and how long young people suffering from eating disorders have to wait for treatment. NHSE explained to us that this is because it took time for the NHS to develop the services including infrastructure and workforce, which were not in place before the standards were introduced. The situation was further complicated by a surge in cases during the COVID-19 pandemic.[26] We are also concerned that performance measures for the current standards may not fully reflect the experiences of people using the services and patient outcomes. In addition, unlike for physical health services, waiting time standards for mental health service only cover a limited number of service areas, and do not apply to the bulk of core community and inpatient mental health services.[27]

16. In 2022, NHSE consulted on new waiting times standards for mental health services in the community and A&E for both children and adults, with most (81%) respondents to the consultation in favour of the new standards. If implemented, these would represent a major extension of performance standards for mental health services. However, NHSE could not confirm whether or when these will be implemented.[28] It told us that it is yet to agree with the Government around "trajectories for working towards meeting those standards" which will in part depend on "having the services and the workforce available".[29]

21 Qq 100, 128–133
22 Q 103; PMS0027, pages 5–6; PMS0017, pages 2–3
23 Qq 17–28, 103
24 Qq 103, 105–115
25 Qq 13, 88, 98; C&AG's Report, para 9.
26 Qq 92–98,
27 Qq 13–17, 30, 33–34, 88–89, 98–100; C&AG's Report, para 2.8
28 Qq 100–101; C&AG's Report, para 1.13
29 Q 101

NHSE explained that it has undertaken a "huge amount of work" to introduce and improve data collection over the last few years in preparation for the new standards. Stakeholders, for example, the Centre for Mental Health, agreed that improving data systems for the new standards was necessary and would take time. But it argued that this was a "chicken and egg" issue, and that poor data should not stop the standards being rolled out as their introduction would provide the impetus for providers to improve data.[30]

30 Qq 29,101

2 Risks to future improvement and sustainability

Delivery through integrated care boards

17. From 2022, the new integrated care boards (ICBs) are responsible for commissioning most NHS mental health services for their local populations. ICBs are NHS bodies, working alongside integrated care partnerships (ICPs) which bring together local government and NHS services on a statutory basis as part of a local integrated care system (ICS).[31] The Department and NHSE confirmed that ICBs will be responsible for bringing forward many of the ambitious programmes which are key to the future of mental health services. This includes, for example, developing new models of community-based mental health services; ensuring data sharing across local NHS, local government and voluntary sector organisations; prioritising capital funding for the growing backlog maintenance of mental health trusts; and workforce planning and deployment.[32]

18. We, and many stakeholders, agree that the introduction of ICSs offers opportunities to improve local mental health services. But many of the challenges they face involve longstanding and unresolved issues which we have repeatedly highlighted, most recently in our April 2023 report on the introduction of ICSs.[33] Only four out of 29 ICBs responding to the NAO survey agreed they had the capacity, resources and staff required to improve their mental health services. As the Department acknowledged, "the proof will be in the pudding".[34] On workforce, NHSE told us that local ICSs are responsible for their own workforce planning. It recognised that there is a tension between central and local decision making, although it is not yet clear where the appropriate balance lies.[35]

19. More immediately, the Centre for Mental Health and other bodies told us that, in the face of funding pressures and the need to reduce backlogs for physical health services, ICBs and ICPs could struggle to prioritise mental health services and support, and potentially even place some of the recent progress made in jeopardy.[36] When questioned, NHSE assured us there is no doubt that "mental health services will remain an absolute priority" for the NHS, and that it has a number of mechanisms in place to ensure that this is the case for ICBs, for example, the mental health investment standard for improving the share of local funding for mental health services.[37]

20. In line with the approach for all health services, the 2023–24 planning guidance for NHS trusts and ICBs reduced the number of nationally mandated objectives to six for mental health.[38] Although the national programme led by NHSE has maintained a consistent focus to date, NHSE and other national arm's length bodies are going through a period of significant change, with mergers and reductions of 30–40% in central staffing. This reorganisation raises many potential risks to NHSE's capacity and ability to monitor

31 C&AG's Report, paras 3, 11
32 Qq 104–105, 121–125, 152–153, 165
33 Q 7; House of Commons Committee of Public Accounts report, Introducing integrated care systems, Thirty-Fifth report of session 2012–23; PMS0015, page 3; PMS0018, page 2
34 Qq 168–171; C&AG's Report , paras 11, 2.17
35 Qq 152–157
36 Q 7
37 Qq 79, 119, 163–166
38 C&AG's Report, para 1.12

and hold ICBs to account.[39] We have also noted recently that support and accountability arrangements for ICSs are still underdeveloped.[40] We asked about inconsistencies in local practice which are of concern, for example, the patchy implementation of clinical guidance for people with eating disorders; but it was not clear to us from the answer how NHSE would ensure that ICBs keep on top of these issues.[41]

Defining the long-term goal of 'parity of esteem'

21. From 2011, the government acknowledged a large 'treatment gap' for people with mental health conditions. It set out that its long-term ambitions were to improve support and services for people with mental health problems and achieve 'parity of esteem' between mental health and physical health services.[42]

22. It is good to see that the number of people accessing NHS funded mental services has increased, from 3.6 million in 2016–17 to 4.5 million in 2021–22. However, this equates to only around one third of people with mental health needs accessing services, with an estimated eight million still not doing so.[43] NHSE acknowledged that, under the current planned rates of service expansion, sizable treatment gaps will persist, even if it meets its access targets for 2023–24. There are also 1.2 million people currently waiting to be seen following their referral to community mental health services.[44]

23. In our 2018 report on mental health services for children and young people, we noted that the Department had not clarified what 'parity of esteem' meant in practice. We recommended that the Department clearly defined the criteria it would use to measure progress and what data/information it required.[45] Many stakeholders who contributed to this inquiry told us that setting out a clear definition of 'parity of esteem', objectives and roadmap to achieve them is important to understand progress and ensure delivery. However, there is still no clear definition of the end goal of 'parity of esteem', 12 years after the government first set out its ambitions.[46]

24. When asked, NHSE told us that it would welcome a definition of 'parity of esteem', which could encompass parity in funding, waiting times and outcomes, as well as the provision of data and information on services. The Department contended that it was not always helpful to have a clear definition and said that its current position is not to provide a specific definition.[47]

39 Qq 147–148; C&AG's Report, para 18
40 House of Commons Committee of Public Accounts report, Introducing integrated care systems, Thirty-Fifth report of session 2012–23
41 Q 92
42 House of Commons Committee of Public Accounts report, Mental health services for children and young people, Seventy-Second report of session 2017–19, para 16
43 C&AG's Report, paras 8,17 and 2.3.
44 Qq 84, 124, 139
45 House of Commons Committee of Public Accounts report, Mental health services for children and young people, Seventy-Second report of session 2017–19, para 10
46 Qq 158–161; C&AG's Report, para 1.15; PMS0026, pages 1and; PMS0015, page 1; PMS0024, pages 1 and 3–4
47 Qq 158–162

Improving preventative and public health services and support for mental health

25. The improvement programme led by NHSE focuses on the expansion of treatment for people who have already developed mental ill health, with limited investment in areas relating to prevention and early intervention such as mental health support teams in schools.[48] Stakeholders highlighted to us the importance of wider social and economic factors such as housing and employment on good mental health. They felt that the current service model is not sustainable without prioritising public health approaches; including preventive measures to stop people from developing mental illness in the first place or early interventions to reduce the need for more intensive treatments.[49]

26. Previous government strategies have emphasised the importance of preventive services for mental health and wellbeing alongside treatment for mental illness. However, we, and many stakeholders, are concerned that preventive and public health services have not been given the same priority and focus as NHS mental health treatment services. From 2018–19 to 2022–23, the local authority public health grant had a real-terms reduction of 6% and in 2021–22, only 2% of total local authority spend on public health was on mental health.[50] The Department and NHSE agreed on the important role of prevention and early intervention, and argued that "a fair amount of progress" has been made in promoting mental health over the last 10 to 15 years, but acknowledged that not all areas were fully mature in terms of preventive infrastructure.[51]

27. We heard that, given the breadth of factors that affect good mental health, an effective preventive programme requires actions from across government.[52] In April 2022, the government, led by the Department, consulted on plans for a new 10-year cross-government strategy on mental health and wellbeing. This has since been replaced by a planned major conditions strategy from the Department, aimed at tackling the six major conditions which contribute to ill health, including mental ill health, for the next five years.[53] The Department explained that "people often have more than one condition at the same time" and "working in disease and condition silos is not always the best way forward". The major conditions strategy will focus on service integration for six major conditions, including between mental health conditions and physical health conditions. The Department confirmed that interim conclusions on the strategy will be available from the summer.[54] While we agree that the major conditions strategy offers opportunities to join up mental health care for patients, many stakeholders have expressed their disappointment that the new strategy, covering mental health as one of a number of conditions, represents a "downgrading" from a dedicated 10-year cross-government plan, and risks the loss of focus on addressing the wider social determinants for mental health.[55]

48 C&AG's Report, para 1.18

49 Qq 6–7, 36–39,45,57,63, 132; PMS0026, pages 5–6; PMS0013, pages 2–3; PMS0011, pages 3–4; PMS0014, pages 4,9–10; PMS0025, pages 1 and 5

50 C&AG's Report, paras 1.18–1.19; PMS0026, pages 5–6; PMS0025, page 5

51 Qq 132, 174,182–183

52 Qq 6–7, 45, 60; PMS0006, page 2; PMS0011, pages 2–3; PMS0014, pages 9–10; PMS0015, pages 2- 3; PMS0025, page 6; PMS0026, pages 1,2 and 8; PMS012, page 1 and 5

53 Q 94; C&AG's Report, para 1.20

54 Qq 118, 170–172, 175

55 Qq 7,35, 63,171; PMS0009, page 2; PMS0026, pages 8–9; PMS0011, pages 1–3; PMS0014, pages 2 and 11; PMS0025, page 1; PMS0024, page 5; PMS0020, page 6; PMS0004, page 2

Formal minutes

Monday 10 July 2023

Members present:

Dame Meg Hillier

Olivia Blake

Dan Carden

Sir Geoffrey Clifton-Brown

Ashley Dalton

Mr Jonathan Djanogly

Mrs Flick Drummond

Peter Grant

Ben Lake

Anne Marie Morris

Sarah Olney

Nick Smith

Declaration of interests

Olivia Blake declared that she had previously been a non-executive director to a mental health charity.

Progress in improving NHS mental health services

Draft Report (*Progress in improving NHS mental health services*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 27 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Sixty-fifth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Thursday 13 July at 9.30am.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 17 April 2023

Chris Dzikiti, Director of Mental Health, Care Quality Commission; **Victoria Tzortziou-Brown**, Vice Chair for External Affairs, Royal College of GPs; **Peter Devlin**, Director of Adult Social Care - Mental Health, Essex County Council & Member of Association of Directors of Adult Social Services; **Andy Bell**, Chief Executive, Centre for Mental Health — Q1–63

Thursday 20 April 2023

Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; **Matthew Style**, Director General NHS Policy and Performance, Department of Health and Social Care; **Amanda Pritchard**, Chief Executive, NHS England; **Claire Murdoch**, National Lead for Mental Health, NHS England; **Professor Sir Stephen Powis**, National Medical Director for England, NHS England — Q64–183

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

PMS numbers are generated by the evidence processing system and so may not be complete.

1 Barnardos (PMS0004)

2 British Association for Counselling & Psychotherapy (PMS0016)

3 British Medical Association (BMA) (PMS0022)

4 Care Quality Commission (PMS0010)

5 Parkinson's UK (PMS0017)

6 Centre for Mental Health (PMS0023)

7 Diabetes UK; MS Society; Marie Curie; Centre for Mental Health; Arthritis and Musculoskeletal Alliance; Kidney Care UK; Kidney Research UK; Neurological Alliance; and Arthritis Action (PMS0009)

8 Mental Health Policy Group) (PMS0026)

9 Healthcare Financial Management Association (HFMA) (PMS0018)

10 Huntington's Disease Association (PMS0002)

11 Local Government Association (PMS0013)

12 Luce, Professor Ann (Bournemouth University) (PMS0008)

13 Mind (PMS0025)

14 Money and Mental Health Policy Institute (PMS0020)

15 NHS Confederation (PMS0015)

16 NHS Providers (PMS0012)

17 National Counselling & Psychotherapy Society (PMS0007)

18 Rethink Mental Illness (PMS0014)

19 Royal College of Psychiatrists (PMS0024)

20 Samaritans (PMS0005)

21 Small Steps Big Changes (PMS0019)

22 The Children and Young People's Mental Health Coalition (PMS0006)

23 The Children's Society (PMS0021)

24 The National Autistic Society (PMS0003)

25 Mencap) (PMS0027)

26 YoungMinds (PMS0011)

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All publications from the Committee are available on the publications page of the Committee's website.

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66th	PPE Medpro: awarding of contracts during the pandemic	HC 1590
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