IMPLEMENTING THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

Foreword

The *Five Year Forward View for Mental Health* has made an unarguable case for transforming mental health care in England. The costs of mental ill health – whether to the individual, their family or carer, the NHS or wider society – are stark. The opportunity of action cannot be ignored, and this document describes how we will take the action required.

Over the past thirty years, mental health services have undergone a radical transformation, and in many areas have gone further in developing multi-disciplinary, community-based alternatives to hospital than any other part of the health system. This should provide the platform needed to build the fuller vision of the *Five Year Forward View for Mental Health* and embed lasting change.

People can, and do, recover from mental ill health. The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality.

But moreover, the evidence is equally clear on the potential gain for the NHS and wider public sector from intervening earlier, investing in effective, evidence-based care, and integrating the care of people's mental and physical health. The case for the *Five Year Forward View for Mental Health*, therefore, is about moving beyond the moral imperative and the clear clinical and individual benefits, and recognising this as a financial necessity to manage the challenges of the years ahead. The implementation plan set out in this document is for the whole NHS, not just for the mental health sector.

Sustainability and transformation plans (STPs) provide the local vehicle for strategic planning, implementation at scale and collaboration between partners. Implementing the commitments of this plan will improve access and outcomes, deliver seven-day services, reduce inequality and realise efficiencies across the local health and care economy and wider society. Mental health should be an intrinsic element of every STP – threaded throughout and not an afterthought.

Implementing this plan will benefit people of all ages, reflecting the specific needs of all groups from children and young people through to older people. As such, our aim to improve mental health and wellbeing cannot solely be achieved by the NHS, but must be delivered in partnership with other local organisations including local government, housing, education, employment and the voluntary sector.

This document lays out a roadmap for delivering the commitments made in the *Five Year Forward View for Mental Health* to people who use services and the public. When implemented, this will lead to an additional one million people receiving high-quality care by 2020/21: a decisive and unprecedented step towards closing the treatment gap for mental health.

Delivering this scale of ambition will be challenging for many; but we must deliver it, and we must be able to show transparently the difference this has made for people. As well as outlining the expectations of the NHS and others, this implementation plan sets out how national partners will work together to provide the right enabling structures and frameworks and to demonstrate progress, as well as the support we will offer collectively to localities over the coming years.

It is now up to all of us to make this a reality.

Claire Murdoch, National Mental Health Director

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1. Introducing the implementation plan

The *Five Year Forward View for Mental Health* has already made the case for transforming mental health care in England. This document does not repeat the many established arguments for increasing priority and funding. The recommendations of the *Five Year Forward View for Mental Health* have been accepted by the NHS – and the purpose of this document is to lay out a blueprint for their delivery over the coming years to 2020/21.

The *Five Year Forward View for Mental Health* is a single programme, but one which contains numerous different, related elements across the health system for all ages. Whilst the vision for improving mental health and wellbeing is wider, this implementation plan focuses primarily on the role of the NHS in delivering its commitments and is directed at commissioners and providers to support and influence their own local plans. However, this blueprint also gives a clear indication to the public and people who use services of what they should expect from the NHS, and when.

Delivery of the *Five Year Forward View for Mental Health* is underpinned by significant additional funding, and this plan sets out in detail where and when this money will become available. However, this is not the only investment in mental health services. This new money builds on both the foundation of existing local investment in mental health services and the ongoing requirement – repeated in the 2016/17 NHS planning guidance – to increase that baseline by at least the overall growth in allocations. Additional funding should not be seen in isolation and should not be used to supplant existing spend or balance reductions elsewhere.

As the plan makes clear in a number of areas, successful implementation of the *Five Year Forward View for Mental Health* is dependent upon establishing services which are sustainable for the long-term. That sustainability is predicated on evidence which shows the savings realised across the health and care system outweigh the investment needed to deliver services. In order to ensure that this fundamental economic case is met, it will be critical for local organisations to agree how they will share both the costs of investment and the proceeds of savings and efficiencies – including how savings will be identified, especially where they accrue in other areas of the health system, and reinvested into mental health services. The development of Sustainability and Transformation Plans provides the opportunity to agree an approach between partners to achieve this aim.

There are many objectives and commitments in this plan which deliver improved access to high-quality care, more integrated services and earlier interventions. A common theme across many objectives is of building capacity within community-based services to reduce demand and release capacity from the acute sector and in-patient beds – whilst in parallel moving the

commissioning model for in-patient beds in mental health towards a more 'place-based' approach so that pathways and incentives are better aligned and efficiencies more readily realised.

The journey to fully transform mental health services – as the *Five Year Forward View for Mental Health* said – should be thought of as longer than a five-year programme. This roadmap prioritises objectives for delivery by 2020/21 and therefore describes the next stages in that journey.

As local areas develop and implement their own plans to deliver the *Five Year Forward View for Mental Health*, it will be important that common principles are followed. These should include:

- co-production with people with lived experience of services, their families and carers;
- working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing;
- identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery;
- designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives; and,
- underpinning the commitments through outcome-focused, intelligent and data-driven commissioning.

The rest of this document falls into chapters which outline the core elements of the programme and provide a roadmap to deliver each of the objectives. These are followed by sections describing cross-cutting work on infrastructure and supporting frameworks, as well as the support offer to localities to help them implement this plan:

Ch2	Children and young people's mental health
Ch3	Perinatal mental health
Ch4	Adult mental health: common mental health problems
Ch5	Adult mental health: community, acute and crisis care
Ch6	Adult mental health: secure care pathway
Ch7	Health and justice
Ch8	Suicide prevention
Ch9	Sustaining transformation: Testing new models of care
Ch10	Sustaining transformation: A healthy NHS workforce
Ch11	Sustaining transformation: Infrastructure and hard-wiring
Ch12	Our support offer

The chapters in this document set out national-level objectives, costs and planning assumptions. In each case, trajectories and assumptions should be treated as indicative to support localities in developing their own plans. Localities will need to assure that their own plans reflect both the existing investment and provision locally and the gap they have identified to meet the objectives in this plan.

2. Children and young people's mental health

2020/21 Objectives

By 2020/21, there will be a significant expansion in access to high-quality mental health care for children and young people. At least 70,000 additional children and young people each year will receive evidence-based treatment – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions.

To support this objective, all local areas should have expanded, refreshed and republished their Local Transformation Plans for children and young people's mental health by 31 October 2016. Refreshed plans should detail how local areas will use the extra funds committed to support their ambitions across the whole local system. Plans should be accessible and include clear numeric targets for improved access to services in each year to 2020/21. These plans will continue to be refreshed annually in line with business planning cycles.

Improving outcomes for children and young people will require a joint-agency approach, including action to intervene early and build resilience as well as improving access to high-quality evidence-based treatment for children and young people, their families and carers.

The national target for the NHS of reaching at least 70,000 more children and young people annually from 2020/21 is expected to deliver increased access from meeting around 25% of those with a diagnosable condition locally, based on current estimates, to at least 35%. These additional children and young people will be treated by NHS-funded community services. NHS England will work with partner organisations across health, education, youth justice, children's services, the voluntary and independent sectors to consider how consequent improvements in access to other services (for example those provided by local authorities and in schools or colleges) will be delivered and measured in parallel.

In delivering this expansion within community-based services, CCGs should commission improved access to 24/7 crisis resolution and liaison mental health services which are appropriate for children and young people. During 2016/17, NHS England will invest in local areas to accelerate work to develop the evidence base and achieve consensus on effective, high-value models of care that can be shared to stimulate further expansion over the coming years.

The table below sets out an indicative trajectory for increased access. This is based on existing data on prevalence of mental health problems in children and young people. It will be reviewed in 2018 following publication of a new national prevalence study, and may be revised.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	28%	30%	32%	34%	35%
Number of additional CYP treated over 2014/15 baseline	21,000	35,000	49,000	63,000	70,000

By 2020/21, evidence-based community eating disorder services for children and young people will be in place in all areas, ensuring that 95% of children in need receive treatment within one week for urgent cases, and four weeks for routine cases.

Recent data suggest that acute admissions for eating disorders are rising[i] and this objective will ensure evidence-based treatment at the earliest possible stage of the illness. In 2016/17, all localities are expected to baseline current performance against the new access and waiting time standard and plan for improvement, in advance of measurement against the standard beginning from 2017/18. As a result of the investment in community-based eating disorder teams, it is expected that use of specialist in-patient beds for children and young people with an eating disorder should reduce substantially.

Data collection to support measurement against the standard above has been introduced in 2016. An expected trajectory for localities' progress towards meeting the standard fully by 2020/21 will be set by November 2016, including plans for a consequent reduction in in-patient beds.

By 2020/21, in-patient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements. Inappropriate use of beds in paediatric and adult wards will be eliminated.

All general in-patient units for children and young people will move to be commissioned on a 'place-basis' by localities, so that they are integrated into local pathways. As a result, the use of in-patient beds should reduce overall, with more significant reductions possible in certain specialised beds.

By 2020/21, inappropriate placements to in-patient beds for children and young people will be eliminated: including both placements to inappropriate settings and to inappropriate locations far from the family home (out of area treatments).

A combination of the different activities to deliver transformation, such as increasing the number of children receiving evidence-based treatment in the community and the development of new models of care (see

chapter 9), is expected to lead to reduced use of in-patient beds for children and young people across all settings, with savings to reinvest in local mental health services. Investment to pump-prime 24/7 crisis resolution and home treatment services should further release money currently within the specialist commissioning budget that can be redeployed to achieve further improvements in access and waiting times in mental health services.

In parallel, NHS England will transform the model of commissioning so that general in-patient units are commissioned by localities on a place basis (whether alone, as part of an STP or another group covering a defined geography), to align incentives and ensure that efficiencies delivered are reinvested in communities. As a first step, all CCGs are expected to develop collaborative commissioning plans with NHS England's specialised commissioning teams by December 2016. These plans will include locally agreed trajectories for aligning in-patient beds to meet local need, and where there are reductions releasing resources to be redeployed in community-based services.

Delivering the objectives: Workforce requirements

Delivering the increase in access to mental health services will require a significant expansion in the workforce. By 2020/21, at least 1,700 more therapists and supervisors will need to be employed to meet the additional demand, in addition to actions to improve retention of existing staff, based on recommended caseloads. This will require new staff to be trained and supervised by more experience staff, as well as return to practice schemes and local recruitment. The table below sets out an illustrative trajectory for the necessary growth in therapists, which reflects the growth in additional funding in CCG baselines. This does not include consequent growth in other staff such as psychiatrists and mental health nurses.

All localities should ensure a highly skilled workforce by working with the existing Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme to deliver post-graduate training in specific therapies, leading organisation change, supervision in existing therapeutic interventions and whole-team development. By 2018, all services should be working within the CYP IAPT programme, leading to at least 3,400 staff being trained by 2020/21 in addition to the additional therapists above. CCGs and providers should ensure that joint agency plans are in place by December 2016 for ensuring the continuing professional development of existing staff for the next five years.

Workforce type	2016/17	2017/18	2018/19	2019/20	2020/21
Therapists	200	428	428	228	52
Supervisors	50	107	107	57	13

Delivering the objectives: Investment and savings

The funding has been profiled to increase CCG allocations over time to support transformation and plan for recruitment of the additional workforce required, as set out in the indicative table below.

Funding type	2016/17	2017/18	2018/19	2019/20	2020/21
CCG baseline allocations					
CYP mental health	119.0	140.0	170.0	190.0	214.0
Eating disorders	30.0	30.0	30.0	30.0	30.0
National programmes (indicative)					
Crisis care models	5.5				
Workforce development (HEE)	38.0	38.0	22.0	17.0	
Workforce development (Other)	18.0	18.0	12.0	4.0	
Specialist in-patient/outreach	21.0	11.0	4.0		
Vulnerable groups	20.0	24.0	25.0	24.0	21.0
Other programmes	13.5	4.0	2.0		

Key

Local Funding
National Funding

The majority of new funding over the period is included in CCG baselines to support delivery of Local Transformation Plans and achievement of the objectives above. However, in line with the vision of *Future in Mind*[II], local agencies should work together to ensure best use of existing as well as new resources, so that all available funds are used to support improved outcomes.

National funding for workforce development comprises both direct funding to Health Education England to commission new training places and deliver the CYP IAPT programme, and funding for provider organisations via CCGs to release staff to attend training courses. The necessary workforce growth can only happen if CCGs, Health Education England and employers all play their part. Separate funding for workforce development is profiled to decrease over time and be mainstreamed within the increasing CCG baseline to ensure sustainability beyond this period.

Additional funding for in-patient services is included in early years to support temporary additional capacity whilst community services are developed and the commissioning model is shifted towards localities. It is expected by 2020/21 that overall bed usage will have decreased and inappropriate out of area placements largely ended; with consequent savings to be reinvested in community-based services, including specialist outreach, to improve access and reduce waiting times.

Further national programmes for vulnerable groups include: developing specialist services for children with complex needs in the justice system; developing a framework of integrated care for the secure estate; collaborative commissioning networks; testing integrated personal budgets for looked after children, care leavers and adopted children; and transforming care for those with a learning disability and/or autism. In addition NHS England is using pump-prime funding during 2016/17 to test and evaluate models of crisis resolution for children and young people. Funding across these areas will be made available to localities taking part in the individual programmes.

Delivering the objectives: Data, payment and other system levers

National data on children and young people's mental health services was included in the Mental Health Services Data Set (MHSDS) for the first time from January 2016. To support transparency, it is crucial that all providers return the necessary data and that commissioners ensure data quality through contract monitoring. As this collection improves, a number of potential activity and outcome metrics will become available to monitor delivery of the objectives above.

The CCG Improvement and Assessment Framework includes an indicator for children and young people. For 2016/17 a bespoke data collection has been established to allow CCGs to provide a self-assessment against progress, including publication of an updated and republished and assured local transformation plan; arrangements for eating disorder services, specialist out-patient and in-patient services; and workforce planning. It is expected that this 'transformation indicator' will be replaced with data from the MHSDS as this becomes more complete over time.

National metrics to demonstrate progress at CCG/STP level will include:

Metric	Source	Availability
CYP MH transformation milestones	CCG IAF / Unify	From Q1 2016/17
CCG spend of additional funding for CYP MH	NHSE finance tracker	From Q1 2016/17
Number of CYP commencing treatment in NHS-funded community services	MH SDS	From Q3 2016/17
Proportion of CYP with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent)	MH SDS / Unify	From Q1 2016/17
Proportion of CYP showing reliable improvement in outcomes following treatment	MH SDS	2018/19
Total bed days in CAMHS tier 4 per CYP population; total CYP in adult in-patient wards/paediatric wards	MH SDS	From Q2 2016/17

There has been significant work to develop a new currency for CYP mental health services. Testing is currently underway of a new method of grouping children and young people according to their level of need. If successful, these groupings could provide the basis for new currencies. A series of intervention codes and outcome tools are being included within the MHSDS and local providers and commissioners should ensure that these data items are collected and reported routinely to enable transparency.

3. Perinatal mental health

2020/21 Objectives

By 2020/21, there will be increased access to specialist perinatal mental health support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it.

The objective above is clear that by 2020/21, specialist perinatal mental health services must be available to meet the needs of women in all areas. This will require closing the gap in the large majority (85%) of localities which are estimated to either have a service that does not meet NICE guidelines, or have no existing service at all. This also includes procurement of additional mother and baby units to increase capacity in areas with particular access issues and review of capacity in existing units, which will be undertaken by NHS England specialised commissioning. The 'perinatal' period is defined as the time from conception until 12 months after the birth of the child.

Delivery of this objective will require the development and integration of both specialist community teams and in-patient mother and baby units, which will work across a defined geography. It will also require that localities maintain existing investment in services in order to deliver the foundations for expansion in access. In 2016/17, local partners should review current provision in line with guidelines and begin to plan for necessary improvements. STPs provide a robust footprint for planning the types of specialist services required.

The table below outlines an indicative trajectory towards the 2020/21 objective. This shows the total number of additional women to be treated each year at a national level, above the baseline.

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
To support at least 30,000 additional women each year to access evidence-based specialist perinatal mental health treatment.	500	2,000	8,000	20,000	30,000

Delivering the objective: Workforce requirements

A highly skilled, confident workforce, with the right capacity and skill mix, is essential to enable the delivery of evidence-based care. Multi-disciplinary teams are vital for perinatal mental health, and must be able to offer psychological and therapeutic support and interventions, nursing capacity, and psychiatry and medication, as well as input from allied health professionals such as occupational therapists, nursery nurses and a relationship with social care. All of this needs to be in the context of understanding the particular challenges and opportunities that occur at this time in a woman's life and the impact of this on her mental and physical health. The relationships with other key groups, including maternity, obstetrics, health visiting and wider mental health services are also vital both for referrals and providing advice and guidance.

To build perinatal mental health capability, Health Education England is leading work to develop a competence framework describing the skills needed in the workforce, for completion by October 2017 This framework will set out the competences in relation to three levels across ten domains, covering generic knowledge and understanding required by all staff, more advanced knowledge required in certain situations, and specialist skills and understanding.

Delivering this objective will also require a significant expansion in workforce capacity, both for in-patient mother and baby units and in perinatal mental health community teams. These requirements will vary significantly across England depending on the starting position for local services. By 2020/21, all teams should be sufficiently staffed to meet the recommended levels.

Staff numbers[III] for a community team with area coverage of 10,000-15,000 births, which will in effect care for 300-500 women, might typically be: 23.5 WTE (including consultant psychiatrist and medical staff, nurses, psychologists, occupational therapists, nursery nurses, social worker, operational managers and administrators).

Staff numbers for an eight-bedded mother and baby unit serving a similar population might be: 33.4 WTE (including consultant psychiatrist, nurses, psychologists, occupational therapists, nursery nurses, operational managers, administrators and housekeepers).

Delivering the objective: Investment and savings

Total additional funding to support delivery of this objective is £365 million over the period. This funding increases each year, reaching £140 million in 2020/21, to meet the needs of all women who need a specialist perinatal mental health service.

Funding type	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
CCG baseline allocations					
Specialist perinatal mental health				73.5	98.0
STF monies for allocation (indicative)					
Perinatal community development fund	5.0	15.0	40.0		
Additional CCG funding to be allocated				11.5	22.0
National programmes (indicative)					
Mother and baby unit development	4.5	10.0	15.0	15.0	15.0
Workforce development	3.0	2.5	2.5	2.5	2.5
Regional perinatal MH networks	1.5	1.5	1.5	1.5	1.5
Other programmes	1.0	1.0	1.0	1.0	1.0

Key

Local Funding
National Funding

Costs have been modelled based on research into the gap between current specialist perinatal mental health provision in England and that required to meet NICE guidelines in all areas[IV]. Funding in the final year (2020/21) is equivalent to the cost estimated to close the gap in full. The profile of funding over the period increases in order to allow for the development of new and improved services, including workforce requirements, in a phased manner.

A perinatal community development fund is proposed to be set up during 2016/17 to invite bids from localities (including STP footprints) to begin to develop specialist teams and to improve quality, with a particular focus on areas of under-capacity. Bids will be invited in the autumn for investment over up to three years as the size of the fund grows. From 2019/20, this will be mainstreamed into CCG allocations.

Savings realised from investment in perinatal mental health services are assumed to fall outside of the five-year period, and hence have not been included.

Delivering the objective: Data, payment and other system levers

At present, there are limited published national measures on perinatal mental health. During 2016/17 we will publish available data and complete a bespoke collection to support transparency, and we will develop a plan for improving data over the coming years in order to better demonstrate improvements to access and outcomes for women. Indicative metrics to monitor achievement of this objective at CCG/ STP level include:

Metric	Source	Availability
Number of women receiving specialist perinatal care in a community team (annual figure)	MHSDS	2016/17
CCG spend on specialist perinatal community services	NHSE finance tracker	From Q2 2016/17
Collection and recording of routine outcomes measures for perinatal MH	MHSDS	In development
Referral to treatment waiting times for access to evidence-based care	MHSDS	In development

We will continue to review the current payment model so that it supports an outcome-based approach, as well as seeking opportunities to embed mental health in other payment systems, such as for maternity.

4. Adult mental health: common mental health problems

2020/21 Objectives

By 2020/21, there will be increased access to psychological therapies, so that at least 25% of people (or 1.5 million) with common mental health conditions access services each year. The majority of new services will be integrated with physical healthcare. As part of this expansion, 3,000 new mental health therapists will be co-located in primary care, as set out in the General Practice Forward View.

In parallel, we will maintain and develop quality in services; including meeting existing access and recovery standards so that 75% of people access treatment within six weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group.

The increase in access to psychological therapies will be targeted. Two-thirds of the additional people receiving services will have co-morbid physical and mental health conditions or persistent medically unexplained symptoms. Many of these services will be co-located with primary and community care, meaning more convenient and tailored treatment and relieving pressure on general practice as set out in the *General Practice Forward View*[v].

Delivering these new integrated services is critical to building care holistically around the needs of the person to improve their outcomes and support them to achieve wellbeing. This approach is also expected to release significant savings and efficiencies for the NHS, based on evidence which demonstrates reduced healthcare utilisation in, for example, A&E attendances, short stay admissions and prescribing costs. Identification and reinvestment of these savings will allow new services to become fully sustainable within 12 months.

During 2016/17 and 2017/18, a targeted group of geographies will work to develop the evidence base for implementing these new services at scale, supported by wider investment in training and infrastructure. From 2018/19 integrated services will be rolled out across all CCGs, in line with the indicative trajectory set out below:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 25% of people with common MH conditions access psychological therapies each year.	15.8%	16.8%	19%	22%	25%
Total number of people accessing treatment	0.96m	1.02m	1.16m	1.37m	1.5m

The objective to maintain and improve quality includes improving recovery rates, addressing geographical variation, improving the availability of choice, and ensuring services are in step with the evidence base. It also means addressing variation in outcomes and access to services for different population groups – including people from black and minority ethnic groups, people with a learning disability, older people, and women in the perinatal period.

Delivering the objectives: Workforce requirements

The expansion of psychological therapies services will require building skills and capacity in the workforce. This includes top-up training in new competencies for long-term conditions and medically unexplained symptoms for current staff, targeted training in working with older people, and training new staff to increase overall capacity – such as the 3,000 additional mental health therapists located in primary care.

The table below outlines the indicative trajectory of additional staff needed to deliver the objective, year-on-year. The number of staff that will need to be trained to supply this workforce will vary by area and may exceed these numbers, taking into account the current trend for a high proportion of psychological wellbeing practitioners to transition to high intensity roles and rates of part-time working.

This is in addition to training needed to maintain the current workforce. Alongside achieving the planned expansion, attention will also paid to issues of sustainability in the current workforce – including improving wellbeing, morale, retention and career development of the people who deliver services to improve stability.

Workforce type	2016/17	2017/18	2018/19	2019/20	2020/21
Psychological wellbeing practitioners	210	350	338	338	338
High intensity therapists	390	650	630	630	630

Delivering the objectives: Investment and savings

The table below sets out the additional investment required to deliver the objective:

Funding type	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
CCG baseline allocations					
Expansion of psych. therapies			157.0	233.0	308.0
National programmes (indicative)					
Investment in integrated services	20.0	88.0			

Key

Local Funding
National Funding

In the first two years funding to support this objective is held centrally, allowing a targeted approach to develop new integrated psychological therapies services. £17.8 million of funding in 2016/17 and up to £54 million in 2017/18 will go directly to training new staff and delivering new 'early implementer' integrated services. Remaining funds in 2017/18 will support further training, quality improvement and expansion of current IAPT services. From 2018/19 funding is in CCG baselines to mainstream integrated services, building on the experience from the first two years.

The majority of investment is for staff training and salaries. As this funding is held locally from 2018/19, sustainability and transformation plan (STP) areas will need to plan for and fund trainees and accredited training courses to meet expansion and savings objectives.

Delivering new integrated services is expected to deliver substantial savings, with services quickly becoming self-sustaining. The table below models expected savings based on the investment identified above:

	2016/17	2017/18	2018/19	2019/20	2020/21
Expected savings: integrated psychological therapies		-26.0	-122.0	-236.0	-364.0

These savings are based on evidence of physical health improvements for people with long-term conditions when co-morbid mental health problems are treated in an integrated way[VI]. Reduced healthcare utilisation in, for example, A&E attendances, short stay admissions and prescribing costs will release funds to enable continued investment in these new services[VII VIII]. The conditions for which there will be the greatest reduction in cost are those for which depression or anxiety co-morbidity leads to a 50-100% increase in physical healthcare costs. The strongest evidence is in diabetes, COPD, cardiovascular disease and for some

people, chronic pain and medically unexplained symptoms. It is expected that over the longer term, fewer complications will result in reduced demand across the pathway.

Further monies are also expected to be released following the closure of in-patient beds for people with a learning disability and/or autism in order to develop community services, as part of implementing Building the right support[IX].

In addition, expansion can further be supported by improvements in productivity of services (which varies significantly) including appropriate use of digitally-enabled therapy. NHS England will be supporting this by setting out a programme for digitally-enabled IAPT in autumn 2016.

Delivering the objectives: Data, payment and other system levers

There is already a well-developed data collection for Improving Access to Psychological Therapies (IAPT) services, and this will be expanded and improved to understand progress and allow services to benchmark themselves. The CCG Improvement and Assessment Framework for 2016/17 includes an assessment of performance against the IAPT recovery rate. The key metrics at a local level are set out in the table below.

Metric	Source	Availability
Current standards: Access to treatment, recovery rate, and referral to treatment time	IAPT regular data publications, CCG IAF	Now
Access and outcomes for different population groups	IAPT regular data publications	Now and in development
Physical health outcomes for people being treated in integrated services	IAPT regular data publications	In development
Healthcare utilisation	National data linkage	In development
CCG spend on IAPT services	NHS England finance tracker	From April 2016
Number of staff co-located in general practice & workforce numbers and capabilities	IAPT workforce census	Now and in development (published annually)

An outcomes-based currency for psychological therapies for common mental health problems has been developed and is already available for local use[X]. The tariff will be applied in shadow form in 2017/18 and implemented in 2018/19.

5. Adult mental health: community, acute and crisis care

2020/21 Objectives

By 2020/21, adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors. This will deliver:

- At least 60% of people with first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral.
- A reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
- A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
- Increased access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

By 2020/21, community mental health services for adults of all ages will be better supported to balance demand and capacity, deliver timely access to evidence-based interventions, integrate with primary care, social care and other local services, and contribute to the delivery of efficiencies across the adult mental health system. Only by doing this can services begin to meet the challenge of closing the treatment gap to improve outcomes and reduce suffering for people with more severe mental health needs.

Within this overarching ambition sit four specific objectives which focus on particular cohorts or outcomes. For people aged 14-65 experiencing first episode psychosis, this will ensure that the full range of NICE-recommended interventions are available in all areas, and improve timely access from the current target in the 2016/17 Planning Guidance. Objectives relating to individual placement and support, psychological therapies and physical health will focus on adults who are in contact or have had sustained contact with secondary mental health services.

The table below outlines an indicative trajectory for delivery of these objectives:

Objective		2016/17	2017/18	2018/19	2019/20	2020/21
Early intervention in psychosis	% of people receiving treatment in 2 weeks	50%	50%	53%	56%	60%
	Specialist EIP provision in line with NICE recommendations[xi]	All services complete baseline self-assessment	All services graded at level 2 by year end	25% of services graded at least level 3 by year end	50% of services graded at least level 3 by year end	60% of services graded at least level 3 by year end
People with a severe mental illness receiving a full annual physical health check			140,000	280,000	280,000	280,000
Doubling the number of people accessing individual placement and support		Baseline audit of IPS provision undertaken	STP areas selected for targeted funding	25% increase in access to IPS	60% increase in access to IPS	100% increase in access to IPS

By 2020/21, all areas will provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.

Out of area placements will essentially be eliminated for acute mental health care for adults.

The Independent Commission on Acute Adult Psychiatric Care painted a picture of an acute mental health system under pressure, with difficulties in access to care compounded by – in some instances – poor quality of care, inadequate staffing and low morale. Too often, inadequate data and information are available to support improvement.

The majority of CRHTTs are not currently sufficiently resourced to operate 24/7, with caseloads above levels that allow teams to fulfil their core functions of a community-based crisis response and intensive home treatment as an alternative to admission. By 2020/21, CRHTTs in all areas should be delivering in line with best practice standards as described in the CORE fidelity criteria . To support the required expansion over this period, all areas should review their current provision during 2016/17 against CORE standards and develop plans to ensure full compliance.

Delivering the expansion of CRHTTs is critical both to alleviate the suffering of individuals in crisis, but also to alleviate pressure on acute in-patient mental health care and tackle inappropriate and expensive acute out of area placements. Inappropriate out of area treatments (OATs) for acute mental health care should be eliminated in all areas by 2020/21.

As a first step towards eliminating OATs nationally, the Department of Health, NHS England, NHS Improvement and NHS Digital have been working with stakeholders to agree a first national definition of OATs alongside a new national data collection that will enable accurate measurement and analysis, including placement type, reason, duration and cost. In 2016/17, all localities should put in place plans to ensure robust monitoring of OATs for all bed types, with the aim of delivering a demonstrable reduction in acute OATs by March 2017.

By 2020/21, all acute hospitals will have all-age mental health liaison teams in place, and at least 50% of these will meet the 'Core 24' service standard as a minimum.

The financial and clinical evidence for liaison mental health services for adults is clear, yet not every acute hospital is equipped with expert staff who are able to assess and care for people with mental ill health skilfully and compassionately whilst supporting and training other hospital staff to do the same. By 2020/21 all acute hospitals will have liaison teams in place in emergency departments and in-patient wards, with at least half providing this on a 24/7 basis in line with the 'Core 24' standard.

The table below outlines an indicative trajectory for the proportion of acute hospitals achieving the Core 24 standard over the period:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
% acute hospitals with an all-age MH liaison service achieving Core 24 service standard	7% (current)	13%	20%	40%	50%

During 2016/17, STPs should develop their approach to liaison mental health to achieve buy-in across the organisations which will commission, provide and partner with those services, and ensure that savings are identifiable in order to be reinvested. This will include consideration of the acute hospitals in the STP footprint that can serve as 'centres of excellence': those already meeting or exceeding the minimum Core 24 standard and those closest to meeting it that can support the development of liaison mental health services across the wider area.

The Core 24 service standard is a standard for adult liaison mental health services. For children and young people, the evidence base on models of crisis response is less well developed. As noted in chapter 3, NHS England is therefore targeting funding during 2016/17 to evaluate models of crisis care for children and young people to achieve consensus on effective, high-value models of care that can be shared to stimulate further expansion over the next five years.

By 2020/21, all NHS-commissioned mental health providers will have armed forces champions and a specific named clinician with an expertise in military trauma.

There will be a network of specialist collaborative providers that have been co-commissioned with CCGs to provide accessible bespoke care for the armed forces community. This will include accessible services for complex post-traumatic stress disorder and other complex presentations that are bespoke for the armed forces community.

The mental health needs of the armed forces (AF) community are subtly different from those of the general population (in terms of complexity), although the overall incidence is not significantly different from other population groups. This includes the presence within the AF community of certain vulnerable groups (including young men and women in the army, the combat arms, reservists and families). However, commissioning arrangements for this community are complex and are split between the Ministry of Defence (for the routine primary, community and secondary care of serving and mobilised reservists) and CCGs (for non-mobilised reservists, veterans and service families, and all crisis care).

Research will be conducted to demonstrate the most effective mental health treatment for the AF community. This will support the development of new services, co-commissioned by CCGs and the MoD, to respond to the particular problems and complex presentations within the AF community, including for post-traumatic stress disorder (PTSD) and substance misuse.

Delivering the objectives: Workforce requirements

Delivering the proposed improvements to adult mental health services will require a consequent expansion in the skills and capacity of the workforce, as well as ensuring collaborative working between mainstream and partner services, such as learning disability and liaison and diversion services, to build the care around the person.

- Early intervention in psychosis (EIP) – Health Education England (HEE) will deliver a programme to ensure there are sufficient numbers of appropriately trained staff to deliver the key interventions recommended by NICE, particularly psychological therapy (cognitive behavioural therapy for psychosis and family intervention) by 2020/21.

- Individual placement and support (IPS) – employment specialists within IPS services are highly skilled non-clinical staff and require a range of qualities and competencies. NHS England will work with HEE and with IPS specialists to develop a competency framework and workforce development strategy to support the planned expansion.

- Physical health checks – additional investment will be deployed to ensure that primary care staff feel confident in actively supporting people with severe mental illness to access relevant physical health screenings and interventions. For example, in a recent survey, 42% of practice nurses reported that they had received no mental health training

at all. The new investment will ensure mental health training and support for staff working in primary care.

- Improving access to psychological therapies for people with psychosis, bipolar disorder and personality disorder – the IAPT-SMI sites have demonstrated the positive impact of access to NICE-recommended psychological interventions on experience, outcomes and reduced healthcare utilisation. NHS England and Health Education England will work to build on the IAPT-SMI programme and 'scale up' so that a greater number of people have access to psychological therapy as a core component of the adult mental health services offer.

- Mental health liaison – to deliver the objective for adult mental health liaison, the existing workforce capacity will need to increase. The workforce requirement for the Core 24 standard was set out in guidance published by the South West Strategic Clinical Network[XIII] and further central guidance will be published later in 2016/17.

Delivering the objectives: Investment and savings

The table below breaks down the additional investment required in the areas outlined to support delivery of the objectives above:

Funding type	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
CCG baseline allocations					
Crisis and acute care		43.0	90.0	140.0	146.0
Early intervention in psychosis		11.0	20.0	30.0	70.0
Physical health interventions		41.0	83.0	83.0	83.0
Armed forces	5.05	5.05	5.05	5.05	5.05
STF monies for allocation (indicative)					
Mental health liaison services		15.0	30.0	84.0	120.0
National programmes (indicative)					
Community mental health			13.0	33.0	50.0
Armed forces	1.68	1.68	1.68		

Key

Local Funding
National Funding

For **crisis and acute care**, the majority of costs will be for new staff in crisis resolution and home treatment teams (CRHTTs) to ensure that effective service models can be properly resourced. A typical CRHTT per 150,000 population would carry a home treatment caseload of 20-30 people, and would comprise a consultant psychiatrist, mental health nurses, approved mental health professionals, occupational therapists, psychologists and support or peer workers.

Funding for crisis care will be supplemented by £15 million of additional capital investment over 2016/17 and 2017/18 to improve health-based places of safety, and will be subject to a bidding process.

For **mental health liaison**, the majority of new investment will fund growth in workforce capacity. A typical 'Core 24' liaison mental health team covering a 500-bedded acute hospital comprises c25 WTE: a mixture of liaison psychiatrists, mental health nurses, therapists and administrative staff[VIII]. Innovative services also include dedicated social work input, such as the liaison service in Bradford, and input from specialist substance misuse clinicians, for example the service in Nottingham, which have also been demonstrated to deliver significant benefits.

Transformation funding for mental health liaison will be made available from 2017/18. During summer 2016 NHS England will work with stakeholders, including the Royal College of Psychiatrists' Liaison Faculty, to model and analyse different options for funding allocation. This will take into account the findings of the third annual survey of the liaison psychiatry workforce (due to report in August). Further detail on the proposed allocation method will be made available in October 2016.

Additional funding for **early intervention in psychosis** estimates the costs for an additional 10% of people to be treated within two weeks as £70 million per annum when fully implemented including costs of workforce development. The profile builds up this steady state over four years from 2017/18, in order to achieve a deliverable phasing of improvement and additional capacity. This funding does not include the baseline monies provided from 2015/16, which are recurrent at £40 million per year over this period.

Funding to deliver **physical health checks for people with severe mental illness** (SMI) will enable CCGs to offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year. The costs (relating to the additional training and capacity needed for the workforce to deliver checks) are based on a pilot enhanced service offered in North East London, the results of which are soon to be published. Development work is ongoing, with the intention to publish further detail on proposed delivery models for this objective by December 2016.

Central programme funding for community mental health services will include amounts to develop a programme to scale up delivery of Individual Placement and Support to reach double the number of people with severe mental illness, and increase the reach of psychological therapies building on evidence from the IAPT for SMI demonstrator sites. This is expected to be targeted and will deliver some savings to both the NHS and Exchequer.

For mental health care in the **armed forces community**, baseline funding from 2016/17 will support specialist in-patient services for PTSD and investment in new online support and regional services. Additional central funding will support co-commissioning work with CCGs for the national procurement of local specialist community services, and investment in research to improve the evidence base on effective interventions for the armed forces community.

As outlined, substantial **savings** are expected to be realised from investment in crisis and acute mental health, EIP services and improved physical health care for people with severe mental illness. The table below sets out the expected savings to be released based on the investment specified above:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
Expected savings: crisis and acute mental health care			-64.0	-135.0	-168.0
Expected savings: early intervention in psychosis		-4.0	-8.0	-12.0	-20.0
Expected savings: physical health care for people with SMI		-27.0	-81.0	-108.0	-108.0
Expected savings: mental health liaison services			-15.0	-30.0	-84.0

In relation to crisis care, the expanded CRHTTs will make a critical contribution to managing the pressures on acute in-patient beds that lead to increased bed occupancy and, ultimately, to people being sent out of area. The acute care pathway (see chapter 12) that will be developed during 2016/17 will incorporate demand and capacity management and will use learning from areas such as North East London, Bradford and Sheffield where the acute care pathway has been redesigned so as to completely eliminate OATs. There is good evidence that once CRHTTs are fully funded and operating effectively, CCGs will be able to cash savings from reduced mental health in-patient activity through elimination of spend on acute out of area placements and bed reductions[XIV].

Expected savings for early intervention in psychosis achieved over this period are based on analysis conducted by the Centre for Mental Health/London School of Economics/Rethink which estimated the savings per person from decreased use of acute mental health services[XV]. Further wider benefits are realised due to improved employment and education outcomes and longer-term reduced risk of suicide.

Savings in relation to physical health screening and interventions for people with severe mental illness are derived from a 2015 QualityWatch report[XVI]. This report demonstrates that in 2013/14, people with severe mental illness had almost seven times more emergency in-patient admissions, and three times the rate of A&E attendances, of which half this activity

was unrelated to mental health need and was instead driven by urgent physical health care needs. Modelling based on the report has identified cash-releasing and capacity-releasing efficiencies from reduced A&E attendances and non-elective admissions realised through improved access to physical health screening and interventions in line with NICE recommendations.

Mental health liaison services are expected to become self-sustaining within 12 months once savings are reinvested, based on a conservative interpretation of the savings predicted by the RAID evaluation (£4 for every £1 invested)[XVII]. These savings are, in the main, capacity-releasing and are derived from reduced acute hospital activity, including reduced admissions and length of stay (particularly for older adults with dementia) and reduced re-attendance.

Delivering the objectives: Data, payment and other system levers

The CCG Improvement and Assessment Framework includes indicators for tracking performance in EIP, out of area treatments and crisis care. It is expected that these 'transformation indicators' will be replaced with data from the Mental Health Services Data Set (MHSDS) in the future.

The new MHSDS enables the routine capture and reporting of information regarding referral to response, assessment and treatment times, interventions delivered (and whether in line with NICE recommendations) and outcomes (clinician and patient reported). There remains significant work required to improve the completeness and quality of data submitted and this will be a key area of focus for NHS Digital, NHS Improvement and NHS England. Other data collections will provide service-level data such as workforce, caseloads and hours of operation.

NHS England will also work with HEE and other partners to undertake an audit of employment services in secondary mental health services. The audit will investigate fidelity to the IPS model and highlight workforce, outcomes and activity of secondary mental health employment services.

Metric	Source	Availability
Crisis care milestones: liaison MH, CRHTTs, places of safety	CCG IAF/Unify	From Q1 2016/17
OATs milestones: monitoring, commissioning plans	CCG IAF/Unify	From Q1 2016/17
Number of non-specialist acute MH OATs	MH SDS	From Q1 2017/18
% of people with first episode psychosis commencing NICE-recommended package of care within two weeks of referral	Unify	Now
% of EIP services meeting full range of NICE standards	CCQI validation of self-assessment	Q4 2016/17
% of acute hospitals with a 24/7 liaison mental health service at minimum Core 24 standard	Annual audit (HEE/ Univ. of Plymouth)	August 2016
CCG spend on: liaison MH in acute hospitals, EIP, CRHTTs	NHSE finance tracker	From Q1 2016/17
Data on access and outcomes for veterans in all mental health services (including IAPT data sets)	IAPT	Now (IAPT) and from Q1 2017/18

The 2016/17 CQUIN on improving physical healthcare to reduce premature mortality in people with severe mental illness is an important lever in addressing the issue of physical health care for this group. It covers in-patient wards, EIP services and community mental health services. NHS England will seek to extend the CQUIN beyond 2016/17, learning lessons about effective delivery and measurement from working with providers and the appointed CQUIN audit partner.

6. Adult mental health: secure care pathway

2020/21 Objectives

By 2020/21, NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people who have severe mental health problems and significant risk or safety issues in the least restrictive setting as close to home as possible.

This should seek to address existing fragmented pathways in secure care, increase provision of community-based services and trial new co-commissioning funding and service models.

By 2020/21, NHS England will invest to increase funding to improve pathways in and out of mental health secure care, with a focus on expanding community-based services for people who require them. This is intended to prevent avoidable admissions and support 'step down' and ongoing recovery in the community as soon as appropriate for the individual and as close to home as possible.

To deliver this, the mental health secure care programme will:

- Trial new models of care within the secure care pathway, and underpin this with a comprehensive support package and longer-term planning to scale up what works.
- Identify an optimal secure care pathway, including community-based interventions, informed by the experience of people in secure services and carers, and the appropriate use of evidence-based interventions, in collaboration with colleagues from the National Offender Management Service and the Ministry of Justice.
- Scope the needs of those using mental health secure services, both currently and predicted into the future, clarifying demand and capacity.
- Map existing service provision and gaps across the pathway, as well as good practice and exemplar services, with an emphasis upon preventing admissions and long term recovery.
- In partnership with others, promote the implementation of personalised recovery-focused care planning in secure in-patient services.

The first comprehensive individual-level and provider-level data collection and analysis of current use of secure care services will report in summer 2016. This will inform numeric targets and trajectories relating to the aims of this five-year programme.

Delivering the objectives: Workforce requirements

To support the objective to transform pathways in and out of secure care, a workforce strategy setting out multi-disciplinary skills and capacity requirements will be produced based on development of community service models, and demand modelling, noted above.

Delivering the objectives: Investment and savings

Additional funding to support transformation of secure services totals **£94 million** over the period from 2017/18 to 2020/21.

The table below shows the breakdown of national and local funding:

Funding type	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
CCG baseline allocations					
Secure care pathway					58.0
National programmes (indicative)					
Secure services transition fund		1.0	5.0	30.0	

Key

Local Funding
National Funding

£36 million funding to support the objective above is held centrally from 2017/18 to 2019/20, to support a targeted approach to trialling the development of community based support for preventing avoidable admissions and enabling step-down from secure in-patient services. The allocation of these funds to specific localities will be determined through a bidding process in 2017/18, including evaluation activity.

In 2020/21, £58 million funding will be disseminated by NHS England in order to mainstream the approach and deliver at scale across the country. It is expected that some areas should be able to start realising savings through reducing spot-purchasing of secure bed capacity and improved management of out of area placements within year. However, further evaluation of models of community care, including a baseline audit and demand modelling, are required to support quantification of potential savings, and none have been included in costing in this year.

Delivering the objectives: Data, payment and other system levers

Data and metrics on spend, access, quality and recovery outcomes will be developed through the trial and evaluation of community-based services, with substantive input from experts by experience, carers and clinicians.

NHS England will work in partnership with regulatory and other arms-length NHS bodies to ensure sustained cross-system support to embed good quality community services within the secure care pathway.

NHS England is trialling new provider-led commissioning approach for medium and low secure services, incentivising least restrictive care, closer to home. The outcome of this 12-month trial will to inform methods of local commissioning of the secure care pathway, to further test before 2020 (see chapter 9).

There has been considerable work already on **payment for outcomes** in secure in-patient care. This will be consolidated and built upon to ensure payment models for the full care pathway incentivise recovery focused care and support for recovery outcomes.

7. Health and justice

2020/21 Objectives

By 2020/21, there will be evidenced improvement in mental health care pathways across the secure and detained settings. Access to liaison and diversion services will be increased to reach 100% of the population, whilst continuing to ensure close alignment with police custody healthcare services.

High numbers of offenders in the youth justice and criminal justice systems have mental health needs and vulnerabilities that go unidentified and unmet. There is a significant over-representation of people with one or more mental health diagnoses within secure and detained settings.

NHS England works with the Ministry of Justice to support the justice reform agenda to secure better outcomes for this population. This includes work to identify and meet need at the earliest opportunity within criminal justice interventions – through reforms in problem-solving courts, the liaison and diversion programme and across the secure and detained estate – to ensure that mental health provision can be adequately and appropriately delivered. NHS England is also securing robust and articulated pathways both across the secure and detained estate for those moving between establishments, and in community-based services for those returning to their communities.

Liaison and diversion provides a multi-agency assessment and referral service within police custody and the courts across England that refers service users into treatment and support where appropriate. This objective commits to expanding access to liaison and diversion services from the current provision reaching 50% of the population to reach all areas in England.

In parallel, NHS England will work with the Ministry of Justice, Home Office, Department of Health and Public Health England to develop a complete health and justice pathway to deliver integrated interventions in the least restrictive setting as appropriate to the crime committed. This will include work with the secure estate for children and young people to improve the delivery of services and transition back to the community.

The table below sets out the indicative trajectory for expansion of liaison and diversion services over this period:

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
% of population with access to liaison and diversion	60%	75%	83%	98%	100%

Delivering the objectives: Workforce requirements

Nursing standard frameworks are currently being developed offering a framework around organisational, clinical, governance and safety standards which will inform the workforce of the particular needs of the secure and detained population, and promote the desired competencies to meet these needs. These standards are part of a re-design of the provider landscape and an intensive recruitment drive to expand interest in this area of work.

Liaison and diversion practitioners are made up of practitioners from various backgrounds including social care, children and young people's mental health, learning disability and a high proportion from mental health nursing.

There is a need for teams that have a wide skill mix to enhance the service offer to people and alleviate local recruitment challenges. This has to be achieved through a number of innovative recruitment and training models.

In order to deliver the planned expansion, there may need to be a consequent 45% increase in the relevant workforce, including liaison and diversion practitioners, specialist workers, support, time and recovery (STR) workers, strategic and team managers and administrators. NHS England is working with Health Education England in order to support this objective.

Delivering the objectives: Investment and savings

Funding to deliver the objective to increase access to liaison and diversion services totals £92 million over the period to 2020/21[XVIII]. This is profiled as set out in the table below:

Funding type	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
National programmes (indicative)					
Liaison and diversion	5.0	12.0	17.0	27.0	31

Key

Local Funding
National Funding

Costs reflect the rollout of service provision across England. These consist mainly of the provision of specialist practitioners to identify mental illness and other vulnerabilities in adults and young people in contact with the criminal justice system, and to support them into appropriate treatment and support services.

These are profiled based on the expected trajectory for expansion across the population set out above. Funding is held centrally in order to enable a targeted approach which responds to gaps in current provision of liaison and diversion, through direct transfer to CCGs.

It is expected that savings will accrue from individuals engaged in treatment requiring fewer GP consultations, hospital admissions and in-patient treatment in relation to common mental health problems, psychosis, personality disorder, and substance and alcohol misuse. In relation to the youth and criminal justice systems it is anticipated that services may bring about efficiency savings through the reduced use of remand and custodial sentencing, by enabling better informed decision-making by justice partners. Savings to the justice system have not been fully quantified at this stage although longitudinal research aimed at evaluating these impacts has been commissioned and will commence in August 2016.

Delivering the objectives: Data, payment and other system levers

Data are collected and monitored to provide assurance across the commissioning responsibilities for secure and detained settings and to support the longitudinal research described above. A smaller set of metrics will be developed based on the findings of the evaluation in respect of liaison and diversion. The table below outlines some of the key available metrics which support benchmarking and monitoring of outcomes in this area:

Metric	Source	Availability
Proportion of people on the Care Programme Approach which was initiated in prison	Health and Justice Indicators of Performance (HJIP)	Now
Number of individuals who have received individual/group therapy within a prison	HJIP	Now
Number of prisoners receiving an initial psychiatric assessment	HJIP	Now
Mental health secure transfers: number of transfers within 2/4/8/12/20 weeks of acceptance under the Mental Health Act	HJIP	Now

8. Suicide prevention

2020/21 Objectives

By 2020/21, the *Five Year Forward View for Mental Health* set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. To support this, by 2017 all CCGs will fully contribute to the development and delivery of local multi-agency suicide prevention plans, together with their local partners.

Delivering the overall reduction in the number of people taking their own lives will in part be driven by the range of objectives set out earlier in this plan, each of which improves access and quality to support people to receive treatment sooner and move towards sustained recovery as quickly as possible.

Suicide prevention is a complex public health challenge and will require close working between the different NHS and partner organisations to build on priorities set out in the National Suicide Prevention Strategy and existing and emerging evidence around suicide such as from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[XIX]. Plans should include a strong focus on primary care, alcohol and drug misuse.

Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Public Health England has produced a range of guidance[XX] for local areas and the wider system to help support implementation of the strategy and is publishing updated guidance for local areas in September 2016 that will support local planning and action across the local system.

Local suicide prevention plans should also agree indicative targets and trajectories for the reduction in suicides, to support transparency and monitoring locally over the period.

Delivering the objective: Workforce requirements

The principal workforce requirements to deliver the objective to reduce suicides are incorporated into each of the individual sections in this plan. In addition, it is likely that local suicide prevention plans will identify a requirement for additional skills and/or capacity to deliver the plans locally across partner organisations (for example gaps in provision for alcohol and substance misuse); although it is anticipated that training programmes could play a significant role in delivering this objective, it is not yet possible to make national assumptions in this regard.

Delivering the objectives: Investment and savings

It is expected that a significant majority of the total funding detailed in this plan will contribute towards the objective to reduce suicides. In addition, a further amount of **£25 million** is being made available over this period to support suicide prevention specifically:

Funding type	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
National programmes (indicative)					
Suicide prevention			5.0	10.0	10.0

Key

National Funding

The additional funding is held centrally and is expected to be allocated to CCGs and their partners from 2018/19, in line with the activity and actions agreed in local suicide prevention plans and further developmental work undertaken at a national level. Further information on the approach to allocation will be provided in 2017/18.

Delivering the objectives: Data, payment and other system levers

The key national metric for monitoring achievement of this objective is set out below. Three-year rolling averages are generally used for monitoring purposes, in preference to single-year rates, in order to produce a smoothed trend from the data.

In addition, localities should agree further metrics to support transparency in monitoring delivery of the agreed actions within their suicide prevention plan.

Metric	Source	Availability
Suicide: age-standardised death rate per 100,000 population	ONS	Now (annual)

9. Sustaining transformation: Testing new approaches

In recent years, there has been an increase in the number of young people and adults being sent for mental health treatment to units many miles from their homes. This practice can make visiting very difficult for local clinicians and friends and family, can affect a person's recovery and lead to increased lengths of stay. Furthermore, this trend has increased expenditure and put additional strain on mental health budgets. This money is then not available to invest in improving the quality of the local services that are so key to preventing the need for tertiary services and improving flow through them. This cycle needs to be broken.

From 2016/17, NHS England will lead a new programme which aims to put local clinicians and managers in charge of both managing tertiary budgets and providing high-quality secondary care treatment. Currently, secondary mental health providers and local CCGs have no responsibility or control over expenditure on tertiary services. This programme will give them the incentive and responsibility to put in place new approaches which strengthen care pathways to improve access to community support, prevent avoidable admissions, reduce the length of in-patient stays, and eliminate inappropriate out of area placements.

A call for applications was sent on 31 May to the chief executive of each NHS-funded provider of secondary mental health services. Thirty-six applications were received, and six sites have been selected to participate. All successful sites will sign an agreement for 12 months and this will be formally monitored and outcomes evaluated.

Delivering the objectives: Investment and savings

A total of **£1.8 million** has been provided in 2016/17 to pump-prime the establishment of new approaches in participating areas. The majority of this will be allocated to successful applicants for activity such as freeing up clinicians to assess and review individual placements; project management for holding specialised commissioning budgets; and strengthening local teams. Funding will not be available for capital developments (this being the focus of the NHS England Adult Secure Care Service Review). The remainder of the transformation funding will be allocated to national support and an evaluation.

Subsequent funding from 2017/18 onwards will be made available subject to the evaluation of the programme in the first year.

10. Sustaining transformation: A healthy NHS workforce

Delivering the objectives in the Mental Health Forward View is not just a question of recruiting and training the right number of staff to improve access. It must also be about ensuring that the NHS looks after its most important asset – its staff – and focuses on promoting their health and wellbeing to improve satisfaction, productivity and retention.

In March 2016, NHS England introduced a £450 million financial incentive focused on improving staff health and wellbeing. To gain access to the money, NHS trusts were asked to improve the health and wellbeing schemes on offer to staff, take action on unhealthy food sold on NHS premises and improve the uptake of the flu vaccination amongst staff.

Mental health support for staff working in the NHS is a key part of this scheme, with £150 million in incentives available for the successful introduction of health and wellbeing schemes, including in relation to mental health. To access this money, providers will be required to take three specific actions on mental health over the course of the next year:

- develop plans to improve the mental health support for all staff;
- implement an improved set of mental health initiatives for staff to access in the workplace; and,
- ensure that locally agreed uptake rates and access metrics are met.

In addition to this, NHS England pledged £5 million in September 2015 to support the development of health initiatives for NHS staff. NHS England is currently supporting 12 pilot organisations in improving staff health and wellbeing, with particular emphasis on mental health, through the NHS Healthy Workforce Programme. The mental health initiatives include:

- **Stress management:** providing the pilot organisations with enhanced line manager training to improve mental health awareness in the workplace. The training specifically deals with stress management by improving line managers' confidence and ability to deal with a range of difficult work-based scenarios.
- **Psychological therapies:** providing additional capacity and training to enable staff to rapidly access evidence-based psychological therapies. This includes helping the organisations who currently have 24/7 telephone-based therapies to enhance these services.

- **Mindfulness:** The Healthy Workforce Programme has partnered with the creators of the mindfulness app 'Headspace' – supporting staff in maintaining their wellbeing. Headspace has provided the 12 pilot sites with a free one-year subscription to the app for all staff.

- **NHS health checks:** providing checks to all staff, including questions on mental health.

The programme will share case studies and the results of an independent evaluation in 2017 to enable other NHS organisations to learn lessons from implementation within an NHS context to help ensure that by 2020 the NHS consistently offers world leading mental health support for its staff.

11. Sustaining transformation: Infrastructure and hard-wiring

Ensuring the sustainability of the transformation described in this document will require significant supporting activity to align the variety of frameworks and infrastructure which drive delivery and focus priorities in the NHS. It will also require strong governance, clear accountability and transparent reporting to monitor progress, identify risks and tackle implementation issues. The section below summarises some of the key activities planned or underway.

Workforce planning

- Health Education England, together with partner organisations, will develop a comprehensive **all-age mental health workforce development strategy** to deliver the full range of objectives in this document. The strategy will build on the requirements outlined in the sections of this document and provide a full and coherent overview of the current workforce and the new skills and capacity needed, and will support detailed planning at regional and local level. It will be published by December 2016.

Data and transparency

- NHS England, NHS Improvement, Public Health England, Health Education England and NHS Digital, together with the Department of Health, will develop a **five-year data plan** to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services.
- NHS England, NHS Improvement and NHS Digital are working with the Department of Health to ensure that the new **Mental Health Services Data Set** (MHSDS) is delivering relevant, timely and accurate data. This includes work to update the dataset and reporting requirements, to ensure the right information is reported nationally, and encouraging providers and commissioners to improve local systems and processes to make the data flow effectively.
- A new **annual schedule of updates to the MHSDS** will allow NHS partners to work together to ensure that the MHSDS is capturing all the relevant data items and give stability to providers and commissioners who are working to implement the changes as soon as possible.
- Through the **Assuring Transformation** data there is now a comprehensive data set on children, young people and adults with a learning disability and/or autism in in-patient settings.

- NHS England is investing £400,000 in 2016/17 to drive forward the work of the **National Mental Health and Dementia Intelligence Network** and is working in partnership with PHE to develop this as a source of high-quality intelligence on the quality of mental health and dementia commissioning and provision across England.

- A **dashboard for mental health** is in development for publication will be developed this year, containing a set of standard indicators to articulate our progress in mental health services at a national level and allow benchmarking of services across the country. This will form the basis of the CCG Improvement and Assessment Framework in subsequent years, and will help us to monitor how our programmes are helping to improve mental health services across the country.

- From 2016 NHS England's **budget and financial reporting** will be aligned to specific mental health priorities, increasing transparency and allowing additional resources to be tracked to the front line. It is expected that these financial data will be included in the dashboard for mental health.

- Mental health is one of the six clinical areas to be covered by the new **CCG Improvement and Assessment Framework**[XX]. Performance against this framework will be transparent, and supported by CCG-level commentary and ratings developed with an independent panel of experts. Over the five-year period the CCG IAF will be developed to reflect performance indicators most critical for mental health delivery across the system.

Payment, outcomes and other system levers

- NHS England has set out a requirement to move towards **accountable payment approaches** in mental health which have a payment component linked to quality and outcomes. This is expected to be implemented for adult mental health from 2017/18, and for children and young people as soon as possible thereafter. NHS England and NHS Improvement and have published resources[XXI] and begun to deliver workshops to support providers and commissioners to implement new payment approaches (including capitated and episodic or 'year of care' payment models). A second series of workshops is planned for delivery in autumn 2016.

- NHS England has published a guide to support local STP footprints to develop a suite of quality and outcomes measures and implement **routine outcome measurement**[XXII]. This will help build the foundations to support outcome-based payment for mental health services in local areas.

- To support the creation of **common outcome standards for mental health** where they do not already exist, NHS England will commission standard sets for mental health conditions, identifying common areas of overlap as necessary. Developing these standard sets will pave the way for benchmarking in mental health.

- The national **CQUIN programme** currently includes two initiatives focused on mental health. The first focuses on identifying and improving levels of staff wellbeing either through the annual NHS Staff Survey or targeted initiatives covering mental health. The second focuses on improving access to physical healthcare screening and interventions to reduce premature mortality in people with SMI.

- Mental health will form a core component of the **quality premium**, providing significant incentive for CCGs and their local partners to collaborate in pursuit of improvements in the quality of mental health outcomes.

- **Local CQUINs** have also been introduced to drive improvement in mental health, including a range of options for local commissioners.

- The **Care Quality Commission** (CQC) already includes a range of data to help them monitor providers of mental health services. This intelligent monitoring helps CQC inspectors to plan inspection activities and to ask questions about the quality of care offered during inspection. NHS England will be supporting the CQC in evolving their programme of inspections for mental health services to ensure that their approach to regulating, inspecting and monitoring mental health care services aligns with the ambitions of the *Five Year Forward View for Mental Health*.

- NHS Improvement is developing their new **single oversight framework** to be introduced from September 2016. This framework will help to identify those providers which may benefit from, or require, support to improve mental health services.

Innovation and technology

- The **National Information Board** (NIB) aims to enable people to make the right health and care choices and support health care professionals in their work by improving digital access to health and care information and implementing digital data standards. In addition to bespoke work such as that detailed above, the five-year data plan will have a focus on ensuring that mental health is well represented across the domains and programmes of the NIB.

- Through the collaboration with the NIB, there will be a critical focus on developing the frameworks for regulation of digitally-enabled mental health services. This will support the evaluation and endorsement of digital tools to support evidence-based mental health care, understanding and promoting the digital literacy and participation of those using mental health services, and setting standards for sharing electronic health records and data. This approach will allow safe and effective implementation across all mental health pathways.

- NHS England is investing £500,000 to rapidly evaluate and scale currently available **digital tools** which directly contribute to improving people's life chances and support their mental health. This work will provide a list of high quality, evidence-based and safe digital tools that will allow commissioners, providers and clinicians to confidently build the technology in to the services they offer. The tools will be available nationally and are expected to be promoted on the NHS Choices website by April 2017.

Governance and accountability

The *Five Year Forward View for Mental Health* report set out a number of recommendations for governing delivery of the vision. In line with these recommendations, NHS England has recruited a new senior responsible officer (SRO) and established three core groups to oversee delivery of recommendations:

- NHS England has appointed a **Senior Responsible Officer for mental health**, Claire Murdoch. The SRO is responsible for overseeing delivery of the *Five Year Forward View for Mental Health* in the NHS, working with all partner organisations.

- The cross-ALB **Mental Health and Dementia Programme Board**, chaired by the SRO, brings together accountabilities for delivering the NHS elements of the programme through executive-level attendees from all key delivery partners, including the National Clinical Director for Mental Health, to coordinate and track progress against plans. This board reports in part to the cross-ALB Five Year Forward View Board.

- The Programme Board is underpinned by an expert **Advisory and Oversight Group** that advises the Board and acts as the panel supporting development and delivery of the mental health dashboard and CCGIAF. This group is chaired by Paul Farmer, former chair of the Mental Health Taskforce, and includes a range of external stakeholders.

- The Board is supported by a delivery-focused body, the **Mental Health Performance and Delivery Group** (PDG) which includes representatives from NHS England's regional teams and NHS Improvement who work closely with providers and commissioners. Regional support and activity is coordinated through the PDG and regional mental health governance infrastructure, which is owned by regional NHS England and NHS Improvement colleagues and varies regionally.

- **Clinical Reference Groups** support delivery of NHS England's specialised commissioning function, by bringing together experts to advise on service specifications and procurement needs to meet the demand for these services.

12. Our support offer

Standards and implementation support

- Over the next five years, NHS England will be working with ALB partners to develop **evidence-based treatment pathways** and the supporting infrastructure required to enable their implementation. Each of the pathways will be designed to span the journey from 'referral to recovery', and across all of the pathways there will be a set of common activities:
  - establishment of a multi-stakeholder expert reference group;
  - development of a pathway that includes expectations regarding referral to treatment waiting times, interventions provided and outcomes measured;
  - specification of the dataset changes required to monitor and evaluate performance;
  - analysis of the gap between current national state and the ambitions in terms of cost, benefits, workforce and timescale;
  - development of a workforce strategy and planning tools to support implementation;
  - development of implementation guidance for the pathway; and,
  - design of levers, incentives and models of payment that support delivery of the pathway.
- Together the full suite of pathways will enable transparent benchmarking against common standards or service ambitions. The table below notes the expected coverage and timescales for delivery of the pathways:

Already published • Early intervention in psychosis • Community services for eating disorders in children and young people (this will be extended during 2016/17 to include in-patient services within the pathway)
Planned for 2016/17 • Generic children and young people's mental health • Perinatal mental health • Crisis care: o Urgent and emergency mental health liaison in acute hospitals(18-end of life) o Urgent and emergency 'blue light' mental health response (all ages) o Urgent and emergency community-based mental health response (18-end of life) o Urgent and emergency mental health response for children and young people • Acute mental health care • Integrated psychological therapies for people with common mental health problems
Planned for 2017/18 and 2018/19 • Community mental health care (encompassing referral to recovery pathways for psychosis, personality disorder, bipolar affective disorder and severe and complex common mental health problems) • Self-harm

- NICE has been commissioned by NHS England to provide a programme of support in relation to the above and this is currently being delivered by the National Collaborating Centre for Mental Health, a partnership between the Royal College of Psychiatrists and the British Psychological Society. Plans for introduction of the pathways above should form part of a response to the Independent Commission on Acute Adult Psychiatric Care.

- The pathways will be supported by self-assessment tools to enable localities to assess their provision against the model pathway. All local teams will be expected to complete a self-assessment to inform development of plans to meet the standards or ambitions set out in relevant pathways.

- Completed self-assessments will be independently validated and scored against a four-point scale on a regular (usually annual) cycle, enabling monitoring of progress along a developmental trajectory. Validated ratings will be made available to support transparency and improvement.

Promoting physical health of people with mental health problems

- Public Health England will work with NHS England to support commissioners to prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes.

- Implementation support has already been made available by PHE in the form of tools (e.g. Lester tool[XXIV]) and guidance (e.g. guidance on smokefree mental health services for commissioners[XXV] and providers[XXVI]).

- Further joint work between NHSE and PHE will extend the range of CQUIN templates and guidance available to commissioners and providers of NHS-funded provision. Topics will include:
  - primary and secondary prevention through screening;
  - NHS Health Checks;
  - interventions for physical activity, obesity, diabetes, heart disease, cancer; and,
  - access to 'stop smoking' services.

Improvement and assurance

A **co-ordinated approach to cross-ALB improvement and delivery support** will be developed further, with details set out later this year for implementation from 2017/18 onwards.

As part of this, NHS Improvement will develop **a new improvement model** to underpin system transformation which is based on improvement science, enables quality improvement and sharing good practice, and complements the pathway approach mentioned above. This will encompass all aspects of mental health delivery, including specialist providers as well as supporting acute providers to meet the mental health needs of the people that they serve. It will consider demand management within secondary care as well as the vital role that primary care and the voluntary sector play in supporting those with mental health problems.

In 2016/17 the delivery support offer for local areas and STP footprints includes:

- NHS England regional teams have been allocated central funding of **£3.4 million** to support delivery assurance and improvement support for mental health, in addition to their core funding. This has been provided across the four NHSE regions.

- This funding in part supports the continued provision of **clinical networks** for mental health in all regions of England. The 12 existing mental health clinical networks provide clinical leadership and engagement and deliver bespoke improvement programmes to CCGs and providers along the pathway, across health, social care and the third sector, to deliver sustainable improvement on outcomes for individuals, aligned to mental health priorities and programmes. The networks will link with HEE local area teams to support workforce planning and development to meet the workforce targets required to improve access.

- Linked to the generic clinical networks, specific **regional networks and implementation teams** have been established to support children and young people's mental health, perinatal mental health and psychological therapies.

- At a regional level, NHSE teams led by **Regional Directors and their Directors of Commissioning Operations** provide an assurance function to support a focus on delivery of commitments (including planning requirements). Regions have different approaches in place, including regional delivery boards which review progress and coordinate assurance and improvement activities, and project management office approaches to maintain oversight of the Mental Health Forward View priorities.

- Health Education England is introducing **Local Workforce Actions Boards** to operate across existing STP footprints to work through and find local system-wide solutions for workforce challenges.

- NHS England hosts **intensive support teams** who can support CCGs and providers to deliver in-year improvements on existing pathways and standards including mental health.

- **National teams** across arm's-length bodies can provide advice and support where local STPs would welcome it, in many cases this will be signposted by regional teams via assurance of STPs or activity plans.

Specific supporting activities

In addition to the general activities, networks and models outlined above, there is a number of specific activities and projects that will provide further support to localities in relation to certain policy objectives. These include:

- A national **commissioning development programme for children and young people's mental health**, to be delivered in 2017 by NHS England. The programme will strengthen the support and development opportunities available to CYP MH commissioners, to help better equip them to reshape the way CYP MH services are commissioned and delivered across the system.

- Public Health England will lead delivery of local implementation support which includes action to deliver the requirement that all local areas have local multi-agency **suicide prevention plans** by the end of 2017. PHE will issue guidance in September 2016 which will cover CCGs, local government, NHS providers, GPs and other partners.

- PHE is also leading this development of the **prevention concordat** programme which will support the objective that all local areas have a prevention plan in place by 2017/18. The concordat is expected to be launched by March 2017 so that localised plans can be put into place over 2017/18.

- An **Integrated Personal Commissioning 'early adopter' programme** for looked-after children will be developed with selected sites from 2016/17, with the intention of rolling the practice out across the sector. This programme will develop a model for the use of integrated personal budgets to improve mental health and wellbeing outcomes for looked-after children and care leavers.

- Support for the expert reference group led by the Departments of Health and Education which aims to develop an evidence based pathway of support and treatment to meet the mental health needs of **looked after and adopted children** and young people across health, social care and education.

I. http://www.hscic.gov.uk/article/3880/Eating-disorders-Hospital-admissions-up-by-8-per-cent-in-a-year

II. https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

III. Recommended staff numbers are from Health Education England, informed by expert clinical advice and based on modified assumptions from the NHS Handbook, rotas for inpatient Mother and Baby Units, and the 2015 Royal College of Psychiatrists Report Perinatal Mental Health Services: Recommendations for the provision of services for childbearing women http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr197.aspx

IV. https://www.centreformentalhealth.org.uk/costs-of-perinatal-mh-problems

V. General Practice Forward View: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

VI. http://onlinelibrary.wiley.com/doi/10.1093/clipsy.6.2.204/abstract

VII. Priorities for mental health: Economic report for the NHS England Mental Health Taskforce. Centre for Mental Health 2015. https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report.

VIII. For examples of projects see: Investing in emotional and psychological wellbeing for patients with long-term conditions, NHS Confederation, 2012

IX. https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

X. https://www.gov.uk/government/publications/local-payment-example-improving-access-to-psychological-therapies

XI. NICE-concordance will be measured during 2016/17 via a self-assessment tool published by CCQI which is to be validated during the course of the year and re-assessed subsequently: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/earlyinterventionpsychosis/theselfassessment.aspx

XII. UCL Crisis resolution team Optimisation and RElapse prevention (CORE) study: https://www.ucl.ac.uk/core-study/workstream-01

XIII. Dr Peter Aitken, Dr Sarah Robens, Tobit Emmens (eds). Model Service Specifications for Liaison Psychiatry Services – Guidance. South West Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions (2014) http://mentalhealthpartnerships.com/wp-content/uploads/sites/3/4-model-service-specifications-for-liaison-psychiatry-services.docx

XIV. Parsonage M, Grant C, Stubbs J. Priorities for mental health: Economic report for the NHS England Mental Health Taskforce. Centre for Mental Health (2016) https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=760ae169-e8df-4616-86a5-d63ea2f00e4a

XV. Knapp M, Andrew A, McDaid D, Iemmi V, McCrone P, Park AL, et al. Investing in Recovery: Making the Business Case for Effective Interventions for People with Schizophrenia and Psychosis. London: The London School of Economics and Political Science, Centre for Mental Health and Department of Health; 2014. https://www.centreformentalhealth.org.uk/investing-in-recovery

XVI. Dorning H, Davies A, Blunt I. QualityWatch research report – Focus on: People with mental ill health and hospital use. The Health Foundation & Nuffield Trust. (2015) http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QualityWatch_Mental_ill_health_and_hospital_use_full_report.pdf

XVII. Fossey M, Parsonage M. Economic evaluation of a liaison psychiatry service. Centre for Mental Health, NHS Confederation Mental Health Network, & The London School of Economics and Political Science (2011) https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=d6fa08e0-3c6a-46d4-8c07-93f1d44955e8

XVIII. Funding is subject to approval by HM Treasury for expansion from 2018/19 onwards.

XIX. http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci

XX. https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance

XXI. https://www.england.nhs.uk/commissioning/ccg-auth/

XXII. https://improvement.nhs.uk/resources/new-payment-approaches/

XXIII. https://www.england.nhs.uk/mentalhealth/resources/

XXIV. http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#cmhresource

XXV. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/432222/Smoking_Cessation_in_Secure_Mental_Health_Settings_-_guidance_for_commis....pdf

XXVI. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/432222/Smoking_Cessation_in_Secure_Mental_Health_Settings_-_guidance_for_commis....pdf

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