NEXT STEPS FOR FUNDING MENTAL HEALTHCARE IN ENGLAND

Infrastructure

ROYAL COLLEGE OF PSYCHIATRISTS
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About the Royal College of Psychiatrists

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and for setting and raising standards of psychiatry in the UK. The College aims to improve the outcomes of people with mental illness and the mental health of individuals, their families and communities.

To achieve this, the College: sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; and works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

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Introduction

Ahead of the publication of the NHS Long Term Plan (LTP), we called on the Department of Health and Social Care (DHSC), NHS England & Improvement (NHSE/I), and other arm's-length bodies (ALBs) of the NHS to:

- commit to the biggest expansion in access to mental health services across Europe, empowering the disempowered with a much-needed focus on tackling inequalities, fit for a modern NHS
- enable the NHS to become the safest, most effective, and transparent health system in the world with mental health NHS trusts leading the way
- empower mental health leaders to develop the healthcare services of the future through Integrated Care Systems and Providers (ICS/ICPs)
- build a strong and resilient mental health workforce, and
- invest in mental health services so that spending on mental health by Clinical Commissioning Groups (CCGs) and NHS England rises from 10.8% in 2017/18 to around 13.1% in 2028/29 of the total estimated NHS England budget.[1]

The LTP, underpinned by a revenue funding settlement of an extra £20.5bn for NHS England by 2023/24 (after inflation), included a commitment that mental health services will grow faster than the overall NHS budget – with a ring-fenced increase in investment worth at least £2.3 billion a year by 2023/24. [2,3] Furthermore, there is an ambition that children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.[4,5]

An ambitious programme of work is now underway to improve and transform mental health services in England – including a pledge to introduce waiting times standards for children and young people's mental health services, emergency mental health services, and adult and older adult community mental health teams – building on the progress made by the Five Year Forward View for Mental Health.[6,7]

When novel coronavirus (COVID-19) was confirmed to have reached the UK on 29 January 2020, shortly before the World Health Organization declared the situation to be a public health emergency of international concern, NHS services began to prepare for widespread transmission and declared the situation to be a 'Level 4' National Incident. [8] [9] One month later, on 28 February, transmission of COVID-19 within the UK was documented and by 1 March 2020, there were cases in England, Wales, Scotland and Northern Ireland.[10]

The pandemic has impacted healthcare provision across the whole of the NHS. For mental health services, some of the expansion programmes have been expedited, such as: establishing 24/7, all-age, open access mental health crisis lines to support people with urgent mental health needs; the creation of mental health A&Es; increased use of digital and remote support technology; and the expansion of children and young people's eating disorder services.[11] At the same time, some mental health services have been required to close or reduce their services (for staff absence or redeployment reasons), and some patients have avoided seeking help for their mental health during the pandemic, particularly via A&E, primary care and in child and adolescent mental health services. Across the health sector, including psychiatry, COVID-19 has also placed major logistical challenges to research and education at a time of pressing need for both.

The mental health consequences of COVID-19 are becoming increasingly evident. Clinicians are reporting increasing numbers of referrals from acute hospitals to liaison mental health services for patients with COVID-related mood and anxiety disorders (including PTSD) and non-delirium COVID psychosis, as well as lockdown-specific deteriorations in patients' mental health due to a lack of face to face contact – such as those experiencing psychosis, eating disorders or obsessive compulsive disorder, or depression prolonged by economic hardship or loneliness.[12]

As the NHS turns its attention to the restoration and recovery of healthcare services, we have argued, along with other healthcare leaders, for a rapid and forward-looking assessment of how prepared the country would be for a new widespread outbreak of COVID-19. While we acknowledge the future shape of the pandemic is hard to predict, local outbreaks are increasingly likely, and a second wave is a real risk. [13] Ensuring mental health services are prepared to manage patients with COVID-19 (both symptomatic and asymptomatic) while they are receiving treatment for their mental health, as well as prevent nosocomial transmission of the virus, is essential. This is particularly crucial as we approach winter given the pressure that brings to the NHS and social care services.

Concurrently, we need to ensure mental health services are prepared to deal with increasing numbers of patients needing treatment and support for their mental health. It is essential the NHS and social care system learn from the first wave of COVID-19 in order to better prepare for subsequent waves, while also adopting innovative new ways of working that have been identified in response to the pandemic.

The third phase of the NHS' response to COVID-19 was outlined on 1 August 2020. As well as downgrading the Incident Alert level from 4 to 3, it included plans to:

- accelerate the return to near-normal levels of non-COVID health services, making full use of the capacity available between now and winter
- prepare for winter demand pressures, alongside continuing vigilance in the light of further probable COVID-19 spikes locally and possibly nationally, and
- doing the above in a way that takes account of lessons learned during the first COVID-19 peak; lock in beneficial changes; and explicitly tackles fundamental challenges including: support for NHS staff, and action on inequalities and prevention.[14]

The Spending Round in 2019 was limited in its one-year settlement for DHSC's departmental budget, committing to a rise of 3.1 per cent in real terms. However, on 21 July 2020, the Chancellor launched the 2020 Comprehensive Spending Review (CSR), which will be published in the autumn and will set out the government's spending plans for the parliament. From this announcement it is now clear that the CSR will set UK Government departments' resource budgets for the years 2021/22 to 2023/24 and capital budgets for the years 2021/22 until 2024/25.[15] This will be critical for NHS trusts, including mental health trusts, to effectively plan for the medium to longer term, as well as deliver national strategies and plans.

Purpose of this briefing

The College has identified four areas that must be fully and sustainably resourced if there is to be the progress in the access to and quality of mental health services that have been promised by government. These include:

- infrastructure
- prevention
- people, and
- technology.

This paper focusing on infrastructure is the first in a series covering these four areas. It considers the next steps for funding mental healthcare in England, with a specific focus on the DHSC's total departmental expenditure limits (TDEL) covering capital spending (CDEL).

Infrastructure is not often given the importance it deserves when it comes to prioritising resources for mental health services. The public, while having an increasing awareness of the need to increase funding for mental health do not necessarily recognise that infrastructure is vital to delivering the LTP and the recommendations of the Independent Review of the Mental Health Act .[16] As part of Government's commitment to achieve parity of esteem, we urge leaders to implement the recommendations set out in this briefing.

The NHS Estate

When the NHS was founded in 1948 its estate was made up of around 3,000 hospitals, many of which required urgent improvement and reorganisation. After just two major injections of capital funding in the 1960s and 2000s, the Naylor Review in 2017 sought to identify opportunities to rebuild NHS infrastructure to meet modern standards of service delivery for the future. The Review concluded that without investment in the NHS estate, the Five Year Forward View could not be delivered, and the estate would remain unfit for purpose and continue to deteriorate.[17]

Across the 51 NHS mental health trusts in England[18], much of the estate is unfit for purpose, posing serious challenges to those who receive treatment and care and to those who work in those facilities.[19]

Infrastructure projects

The Health Infrastructure Plan (HIP) is a five-year rolling programme of investment in NHS infrastructure taking a strategic approach to improving hospitals, primary and community care estates and health infrastructure, with waves of investment in new infrastructure initiatives.[20] The programme is supported by the Government's new national construction framework, ProCure 2020, which is working with new hospital building projects up until 2030.[21]

We understand the HIP capital projects were selected by looking at priorities within ICSs.[22] None of the six hospital trusts given funding to develop a new hospital, or the 21 schemes given seed funding, were for mental health hospitals/facilities.[23] There were 205 other proposals across Sustainability and Transformation Partnerships (STPs) outside of HIP1 (2020-2025) and HIP2 (2025-2030), but since July 2017, just 11 mental health trusts have received STP full business case approval for 16 infrastructure projects, totalling £68.6m Public Dividend Capital allocations.[24]

Capital investment by Government and DHSC

In 2018/19, the DHSC spent £5.9bn on NHS capital – 60% of which was spent by NHS trusts in England. The Health Foundation argued that an additional £3.5bn of capital funding was needed for the NHS in England, on top of the current capital budget in 2018/19, and rising to £4.1bn by 2023/24 in order to bring the NHS up to OECD average.[25]

The Spending Round in 2019 committed to upgrade 20 hospitals and was underpinned by £854 million of new funding, alongside a £1 billion boost to NHS capital spending in 2019/20 via the HIP.[26,27]

The Government also committed to providing the NHS with a new multi-year capital settlement at the next Spending Review (2020), including capital to build new hospitals, for mental health and primary care, and to modernise diagnostics and technology.

Subsequently, amidst the COVID-19 pandemic, the Prime Minister has announced a further £1.5bn of nationally allocated funds for NHS providers to spend in 2020. This is earmarked for hospital maintenance, eradicating mental health dormitories, enabling hospital building, and improving A&E capacity.[28] This will look to deliver a smarter, more strategic long-term approach to the country's health infrastructure, with investment focused on local areas where the need is greatest. Specifically, this is being split into three funds: NHS maintenance and A&E capacity (£1.05 billion in 2020/21), modernising the NHS mental health estate by replacing dormitory provision (£250 million in 2020/21) and accelerating a number of the 40 new hospital building projects through the HIP (£200m).[29]

The Secretary of State for Health and Social Care has also confirmed that future phases of the HIP will give the NHS opportunities to put forward further new hospital projects for the next phases of the programme.[30]

In addition, HM Treasury created an emergency response fund for COVID-19 initially set at £5bn.[31] This was subsequently raised to £6.6bn for the NHS and £1.6bn for local authorities.[32] This is to cover any COVID-related costs and is not for capital specifically. A further £3bn of additional funding was announced in mid-July to allow the NHS to continue to use the extra hospital capacity acquired from the independent sector and also to maintain the Nightingale hospitals, until the end of March.[33]

Capital expenditure by NHS trusts

In 2017/18, mental health trusts accounted for 9% of all capital spending, acute trusts for 78%, and specialist trusts for 8%. By comparison, revenue shares were 14% for mental health trusts, 75% for acute trusts, and 5% for specialist trusts.[34]

In 2018/19, while capital expenditure was ultimately below planned levels across all NHS trust types (with the exception of ambulance trusts), it was within mental health trusts where the shortfall was greatest in percentage terms. Capital spend amounted to only £481m in 2018/19, 28.0% below the planned £668m. This compares to 15.3% below planned spend across all trusts, 22.4% within specialist acute trusts, 13.1% within non-specialist acute trusts and 9.6% for community trusts.[35] This follows an even greater shortfall against planned capital investment in 2017/18 for mental health trusts of 38.9% (£280m invested against a plan of £458m) compared to 29.1% for all trusts.[36]

For 2020/21, NHSE/I have confirmed a net increase of £683m funding for NHS operational capital. This means the NHS provider capital allocation for 2020/21 has been set at £5.8 billion, compared to a forecast outturn of £4.5 billion in 2019/20.

NHSE/I state that NHS provider capital allocation will be split as follows:

1. **System-level allocation** (£3.7bn) – to cover day-to-day operational investments (which have typically been self-financed by organisations in the ICS/STP or financed by DHSC through emergency loans). NHSE/I hope to be able to set these allocations over a multi-year period in future, subject to the outcome of the Spending Review 2020. Capital requirements agreed as part of COVID-19 costs will be funded on top of these envelopes.
2. **Nationally allocated funds** (£1.5bn) – to cover nationally strategic projects already announced and in development and/or construction such as hospital upgrades, diagnostics machines, and new hospitals. These national programmes are subject to specific HMT conditions and Ministerial delivery requirements.
3. **Other national capital investment** (£0.8bn) – including national technology capital provided by NHSX. Elements of this may be subsequently added into system-level or national level allocations during the financial year.[37]
   A further update on system financing is due imminently from NHSE/I.

ICSs are responsible for system transformation and collective management of system performance. This includes capital and estates plans at a system level. This will make for more complex and time-consuming negotiations between system partners and will be impacted by the maturity of ICSs.

As NHSE/I ask all NHS providers to submit estate plans taking account of their known funding sources and schemes that have already received DHSC funding approvals, including STP capital programmes[38], we are concerned that NHS mental health providers will lose out if concerted, targeted action is not taken. Mental health providers often receive a disproportionately lower amount of capital funding compared to other providers across the local health economy.[39] [40] There are other concerns relating to the capital allocation formula considering pre-existing schemes, thus reducing the total amount available to system providers within a given year.

Why capital investment in mental health services is urgently needed

We need to ensure mental health services are resilient and clinicians are prepared to manage patients with COVID-19 while receiving treatment and support for their mental health, as well as preventing nosocomial transmission of the virus in these settings

The COVID-19 pandemic has demonstrated that many mental health buildings are not fit for purpose, both across the community and inpatient estate.

Many buildings have been designed to address safety concerns, such as fire, self-harming and violence, but not infection prevention and control. It is paramount that mental health services prevent nosocomial transmission of the virus in inpatient settings, as well as preventing the spread in the community. People who have a mental illness are also more likely to have poorer physical health than the general population, making them more susceptible to the virus.[41] This includes higher rates of smoking, respiratory disease (COPD, asthma, chest infections), substance use disorders, as well as malnourishment caused by metabolic problems or eating disorders. Protecting both patients and staff requires different ways of working from usual practices, but would prevent significant morbidity, mortality and would reduce the pressure on acute physical health services.

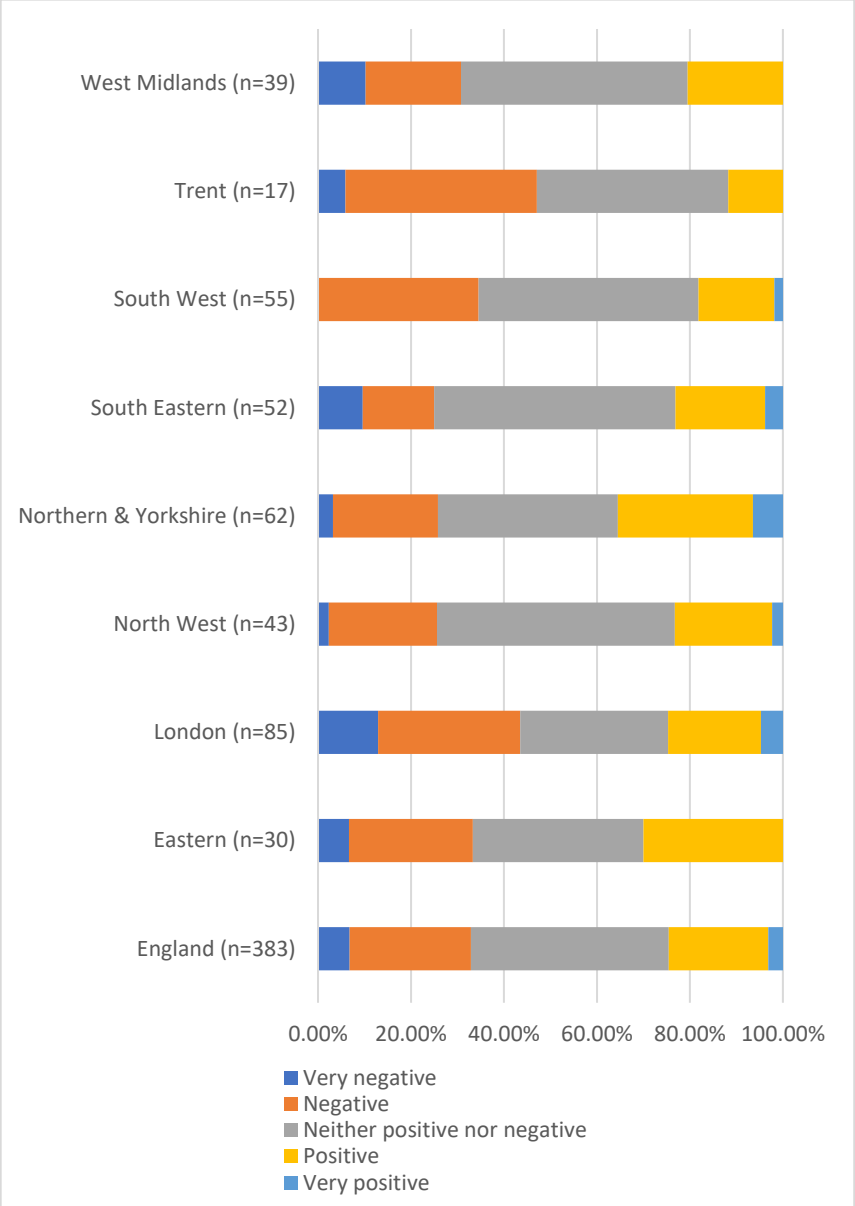
In March 2020, Sir Simon Stevens and Amanda Pritchard told Mental Health, Learning Disability and Autism providers to plan for COVID-19 patients at all inpatient settings, asking them to identify areas where patients requiring urgent admission could be most effectively isolated and cared for.[42] Subsequently, we co-produced guidance with NHSE/I for inpatient settings, which recommends that clinicians should 'cohort' (separate) patients into those with confirmed COVID-19 and those without confirmed COVID-19 (further guidance in box below).[43,44]

- Providers should consider whether it is possible to reconfigure the inpatient estate to create 'cohorted' wards to reduce the risk of contagion among specific, vulnerable groups. In doing so, inpatient settings should **reorganise wards/bays/en-suite facilities and staffing arrangements to separate these cohorts of patients, to maximise protection for the maximum number of patients**.
- Vulnerable groups include but are not limited to older adults with frailty, patients with a BMI of 40 and over, pregnant women, patients with an eating disorder, and patients with physical co-morbidities as outlined in Public Health England's guidance on vulnerable groups.
- To follow the PHE guidance on self-isolation, patients with the virus will **require single-room accommodation and access to their own bathroom**. This will require a flexible approach to accommodation and reconfiguration of the estate, potentially across a group of providers, including the independent sector, in a provider collaborative or local geographical footprint.
- Providers will also want to consider **enhanced physical monitoring** and **measures to support infection control,** such as no visitors allowed, on these cohorted wards.
- Providers will also want to consider whether wards are able to provide **flexibility in the management of acuity** – for example, by bringing high dependency unit capacity onto a ward if required to prevent vulnerable patients being transferred between wards.
- Providers may similarly want to consider whether **usual restrictions on ward types can be relaxed**: for example, where ward type is based on age, sex or diagnostic group on a case-by-case basis. A record of decision-making and ethical considerations should be kept. Specific local arrangements will need to be kept under regular review as the size and gender mix of these cohorts are likely to change over time.
- Providers will want to consider where enhanced mental healthcare may be needed to **mitigate the impacts of isolation**, and the use of digital technology to retain social connections.

Cohorting patients under these circumstances is likely to have meant that providers breach current guidance on delivering same-sex accommodation. Clearly in the longer term, cohorting patients by infection status should just be one element of this process. The mix of patients is critical to safety and therefore age, sex, type of illness (functional/ organic), and behavioural needs also need to be considered.

Our recent membership survey found that 32.9% of clinicians said that the quality of buildings and estates in their organisation has negatively or very negatively impacted upon the care provided to patients during the pandemic (Chart 1).[45]

Chart 1. What impact has the quality of buildings and estates in your organisation had upon the care provided to patients during the pandemic?



"No place to do proper donning and doffing of PPE. No handsfree handwash like in theatres and acute hospitals. No space for social distancing. No space for patients to isolate. Mental health setting was basically a disaster waiting to happen when pandemic struck us."

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"There has been a longstanding and acknowledged deficit in the quality of mental health estates in the NHS. Such deficits have only been notable during a time of significant systemic stress."

"It's not fully possible to zone inpatient wards into red/amber/green areas as we cannot physically separate areas and bedrooms are not en-suite."

"COVID-19 spread rapidly on my ward in March. Six patients and multiple staff tested positive. Most patients were in bays. Only one side room has an en-suite."

"We have 4 bedded dormitories so patients can't be isolated or shielded. We only have 3 single rooms."

"Red/ green zones have been easier - the biggest challenge is "amber" patients i.e. those waiting on swab results/ those with symptoms but swabbing negative."

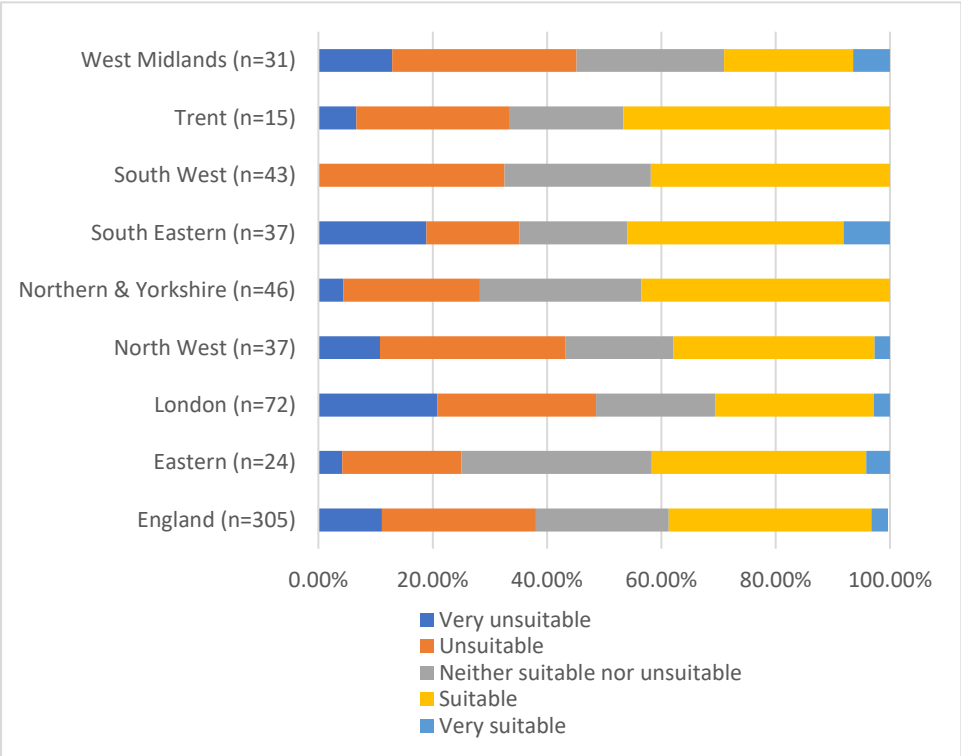
"All mixed gender for cohorting."

"Lack of single rooms has led to spread of virus between patients."

"Inpatient ward area while modern purpose-built building had still been challenging managing COVID risk in dementia care setting. Luckily as modern building and designed for male female separation have had some flexibility. However, a lot of older style accommodation must be a challenge. Similarly, as we look towards re starting outpatient care as recently refurbed community site large outpatient rooms and lots of space so will be able to accommodate social distancing. Just have to wait for rooms to be vacated by people using them as office space."

Furthermore, 38.0% of members said that their organisations' estate has been unsuitable or very unsuitable for the cohorting of patients with suspected or confirmed COVID-19 (Chart 2). Conversely, it is clear that where the mental health estate has been modernised, it has had a positive impact on both patients and staff during the pandemic.[46]

Chart 2. How suitable have the estates been in your organisation for the cohorting of patients with suspected or confirmed COVID-19?



"New built inpatient unit on same site as acute, all single rooms and we had flexibility of being able to partition wards and flex beds up and down."

"Due to number of wards and newness of buildings, they are easy to clean and also able to split ward into COVID positive, negative and new admissions awaiting testing."

"Some rooms are too small for social distancing when seeing patients. It is paramount that all offices and clinical areas are cleaned regularly. I am unsure if the right protocols for this are in place."

"A COVID ward was identified within the organisation. However, this was done rather late, when virtually every ward in the organisation had anything between 2-6 patients who were unwell with COVID. My ward is an old style ward on an acute hospital site with 4-bedded bays, and only 2 side rooms, so it became challenging to manage COVID positive unwell patients, and we had to quickly make other changes such as converting a communal quiet room into a third side room. The community teams have been remote working from home at present; however, plans to relocate community services into team hubs sitting around 40 people in a room, with hot-desking at a ratio of 4:1, with very little break-out space had been on hold. It remains a concern for how this agenda can be moved forward safely especially with the high number of BAME staff who are at higher risk of catching the disease, and with worse outcomes.

In addition to the need to cohort patients, space is also required for education / training of NHS staff (including sessions on 'how to put on Personal Protective Equipment (PPE)') as well as conducting different types of research. Across NHS mental health sites, there is competition for clinic rooms for quiet spaces to do this work, and there may be a need for equipment to be maintained or access to medicine and/or lab like

facilities. Therefore, when reconfiguring or building new spaces for research and education, COVID-19 factors also need to be considered.

The third phase of the NHS' response to COVID-19 set out on 31 July 2020 outlined that all NHS providers should prepare for winter alongside a possible COVID-19 resurgence and continue to minimise nosocomial infections across all NHS settings. [47]

We need to ensure the safety of patients and staff

The Independent Review of the Mental Health Act found that patients in mental health facilities are often placed in some of the worst places in the NHS estate. The Review found that badly designed, dilapidated buildings and poor facilities are not a safe place for staff to work and for patients can contribute to a sense of containment atmosphere and make it hard for effective engagement in therapeutic activities.[48]

The Care Quality Commission (CQC) State of Care report on mental health found that many mental health wards are unsafe and provide poor quality care in old and unsuitable buildings. The CQC argue that the design of many of these buildings do not permit staff to observe all areas easily and many wards contained fixtures and fittings that people who are at risk of suicide could use as ligature anchor points.[49]

NHS Providers' analysis also showed the continued under-prioritisation of investment in the mental health estate is having a demonstrable impact on patients.[50] There were seven never events reported in mental health trusts in 2018 as a result of a shower/curtain rail failing to collapse.[51]

A recent NHS staff survey showed that more than one in five workers in mental health trusts witnessed an error, near miss or incident that could have hurt a member of staff in the last month.[52] Safety concerns raised by RCPsych members have included a lack of safe places for clinical assessments, a lack of a proper alarm system and unsafe procedures/protections for handling toxic or dangerous products such as used needles.

The CQC also found that sexual safety incidents are common on mental health wards and affect not only service users, but also staff and visitors.[53] Following a review of incident reports on NHS mental health wards over a 3-month period in 2017, they found that 1.6% were related to sexual safety. The National Collaborating Centre for Mental Health (NCCMH) is developing standards and guidance on improving sexual safety in inpatient environments as part of a Collaborative. Through their ongoing work, they have identified that mixed sex accommodation still exists across the country and significant investment and assurances to prevent out of-area admissions would be required for these to be completely eliminated.[54]

There are currently many examples of good and outstanding care in mental health settings – but also too much poor care, and variation in quality and access across different services. Of the 51 mental health trusts rated by the CQC as of July 2020, only 47.1% are rated as good on safety (none as outstanding), which is better than the acute sector at 33.1%, but also remains well below community trusts (66.7%).[55] The biggest concerns relate to the poor physical environment, restrictive interventions, sexual safety, safe medicines management and low staffing levels. A mere 30.2% of all trusts with acute wards for working age adults and psychiatric intensive care have secured good or outstanding ratings for the safety of those facilities. Despite this, currently, 78.4% of mental health trusts are rated as good or outstanding for being well-led and 3.9% are rated as inadequate. This compares to the acute sector where 69.0% are good or outstanding and 3.5% are rated as inadequate.[56]

Building on this foundation, the Government should aim to make mental health services in England some of the safest in the world.

We need to ensure the built environment supports patient outcomes and recovery, rather than hindering them

Every patient wants the best chance possible to get better. Improving the mental health estate requires a concerted focus on reducing harm, but there are also opportunities to think innovatively and improve the quality of the environment that goes beyond harm reduction so that it makes a positive impact on a patient's health.

The vast majority of mental health care is delivered in the community. This occurs in clinics, psychological therapies, group work, 1-2-1 support for people with a mental illness, intellectual disability and neuropsychiatric disorders. The environment is the first indication of the value we place on people; the place where difficult memories are recounted, and hard conversations are had. It is where prevention happens, where escalation into crisis is avoided and where healing and recovery may begin.

For those people who do need a hospital admission, many mental health hospitals are unable to provide a therapeutic environment and to maintain privacy and dignity. Patients admitted are often detained under the Mental Health Act 1983, and have longer admissions than patients in general hospitals, so having a high-quality therapeutic environment is essential. The provision of gym facilities as well as facilities for gardening and outdoor sports as part of inpatient wards is very beneficial. This is important considering the fact that most of the inpatient wards have become non-smoking areas.
Any new capital project also needs to consider the huge impact mental illness has on an entire family network and include innovative ways to ensure those who use inpatient services are able to access their family and private life during their inpatient stay. Many inpatient services have had to deal with real challenge as carers, family members and parents were unable to visit during the height of the COVID-19 pandemic, and visiting policies are likely to be altered for many months.

We commissioned a report in 2019 which identified the need for additional inpatient beds in some areas of the country to meet the recommended rate of 85 per cent bed occupancy across all STPs and reduce out of area placements.[57] A programme is already underway to commission more CAMHS tier 4 beds, secure care beds and mother and baby units, which has been well received.[58]

There is also a need to ensure the mental health/learning disability estate (both inpatient and community) is fit to accommodate patients with disabilities, including but not limited to the frail elderly. Patients who use wheelchairs, who are visually impaired or are hard of hearing need to be able to access and benefit from mental health and learning disability/autism services in the same way as other people without a disability would be able to. This is likely to become increasingly important with an ageing population with multiple morbidities.

For patients who are presenting via an emergency route, safe and appropriate spaces in A&E as well as appropriate mental health transport vehicles, is essential. The Independent Review of the Mental Health Act made the following recommendations to local areas:

- alternative forms of provision for those in crisis or requiring a mental health inpatient admission e.g. sanctuaries; safe havens and crisis cafes; crisis houses
- new mental health transport vehicles to reduce inappropriate ambulance conveyance or by police to A&E, and
- appropriate assessment spaces in A&Es for people with mental health needs.

The NHS Mental Health Implementation Plan states that every area will be expected to increase the range of services available locally that provide an alternative to an admission. The alternative services will require co-production with service users, recruitment of peer support workers, a prominent role for local voluntary sector organisations, and will be expected to include options that are tailored to meet needs of specific locally identified priority demographics and inequalities.[59]

We need to ensure the built environment contributes to staff morale and increases retention

The built environment can severely affect not just the health and wellbeing of patients, but also that of staff. NHS leaders have recently highlighted this in calling for increased capital investment.[60] We know that working in new modern buildings makes a huge difference to morale. Improved facilities contribute to feelings of morale, pride as well as productivity.[61]

Recent research from Think Ahead suggests that the public may have negative misconceptions around working in mental health, such as the belief that mental health professionals work long and unsociable hours, have high levels of stress, and have to deal with significant amounts of paperwork. It is important, therefore, that the built environment does not also contribute to these negative public perceptions.[62]

Research has also demonstrated the importance of green space and access to nature for people's mental health and wellbeing. These findings suggest that the inclusion of green space in the development of the healthcare built environment would be positive in supporting the wellbeing of both patients and staff.[63]

As the NHS attempts to become a better place to work through a new Core Offer, including action to support the changes healthcare professional say will make a positive difference to their working lives and experiences, the role of mental health buildings and the wider estate should play a key part.[64]

We need to ensure mental health trusts are able to contribute to the NHS' goal of providing sustainable healthcare, embedding nature within its service design

The Climate Change Act 2008 sets out legally binding carbon reduction targets for the UK government to achieve. The UK government target is 34% reduction in carbon emissions by 2020 from the 1990 carbon baseline. The NHS is a significant carbon emitter.

The NHS Sustainable Development Unit (SDU) defines a sustainable healthcare sector as one that involves 'greening' the sector with attention to energy, travel, waste, procurement, water, infrastructure adaptation and buildings. This ensures resources (physical, financial and human) used in the sector are used efficiently (e.g. buildings and homes are well insulated and use less fuel to heat) and used responsibly (e.g. clinical waste is disposed of safely to protect local people).[65]

The NHS LTP set out several environmental and sustainability targets, which are outlined below:

- by 2025, the NHS will reduce our carbon footprint by 51% against 2007 levels, by greening our estates and facilities, including phasing out coal and oil fuel as primary heating
- by 2023/24, the NHS will cut business mileages and fleet air pollutant emissions by 20%, and
- the NHS will deliver reductions in single use plastics throughout the NHS supply chain.[66]

Replacing ageing buildings across mental health trusts will help Government meet the NHS' environmental and sustainability targets and improve its response to the climate and ecological emergencies.

In addition to sustainability, there are opportunities for mental health trusts to embed nature within service design, which will have a positive impact on mental and physical health. For example, there is a joint initiative between Lancashire Care NHS Foundation Trust and The Lancashire Wildlife Trust which has empowered almost 260 young people, in the Preston, Chorley and East Lancashire areas (aged 13 to 24 years) to take action within their local greenspaces that both improves their health and wellbeing as well as benefitting their local community. The aim of the project is to support 1,000 young people in central and east Lancashire to participate in outdoor ecotherapy based activities that improve their mental health and physical wellbeing.[67]

Building on this rationale, we have identified six actions for NHS mental health providers and CCGs, followed by recommendations for the Government and ALBs.

Actions for NHS providers

Action 1: NHS mental health trusts to review their estate and repurpose vacant property and/or procure and implement temporary modular facilities to increase real estate capacity during the COVID-19 pandemic (if required)

"We created a quarantine area on our dementia ward for new admissions to be isolated as well as any positive cases. I was anxious that this would be a poor environment but in fact we were able to have large en-suite bedrooms, a bathroom and a living area and patients have not been distressed being there. We did not have enough space to have an amber and a red area which would have been even better."

NHSE/I's guidance is clear that providers should be reconfigure the inpatient estate to create 'cohorted' wards to reduce the risk of contagion. Providers were asked to consider:

- how additional, single-room accommodation for patients with the COVID- 19 virus could be provided in partnership with the independent sector (which may offer a higher proportion of single-room accommodation)
- whether modifying any available capacity within the adult secure estate is possible, to accommodate voluntary patients, and
- analysing and mapping the current inpatient estate to identify key gaps, risks and pressures and developing a number of contingency plans to match likely scenarios, in partnership with other inpatient providers locally.[68] [69]

Similarly, for those mental healthcare professionals working in the community, there needs to be sufficient and appropriate space for staff to socially distance, don and doff PPE, and carry out hand washing, showering or changing clothing in order to follow infection prevention and control guidance.

Yet, our members in some areas report this is not happening because of limited real estate capacity, or lack of strategic planning.[70] This needs a full assessment and remedial action in the community office and the community clinical estate as well as in the inpatient and crisis environment.

In response to COVID-19, NHS Property Services (NHSPS) have issued a Technical Guidance document to support the procurement and implementation of temporary modular units (prefabricated structures, with sections delivered on site to be assembled) on the NHS estate.[71] In parts of the health service, NHS trusts have commissioned modular buildings quickly.[72] Potential options include standard bedded wards, shell portacabin (for fit out by NHSPS for other use as required) and shower block/changing facilities.[73]

In Mental Health settings, this is not necessarily about increasing the total number of beds but increasing the number of buildings/ sites in which those beds are located for cohorting. There would be special requirements for any modular build to be used in mental health settings, perhaps focusing predominantly on the 'fittings' to be used e.g. different doors/taps/curtain rails etc. [74] Further information on modular builds in mental health settings are provided in Appendix 1.

Alternatively, and where immediate demand is required, NHSPS has a designated taskforce to re-purpose vacant property which can potentially provide vital healthcare space quicker than the provision of modular units.[75]

This might also be helpful when considering temporary decant facilities while construction is underway for other projects, such as eliminating dormitory provision.

Action 2: NHS mental health trusts to replace dormitory accommodation with single en-suite rooms

CQC data published by the Health Service Journal in June 2019 showed that around 7% of mental health beds were still located within dormitories, equivalent to 1,176 beds across more than 300 wards nationwide.[76] Around 64% of the beds are on adult acute wards and psychiatric intensive care units with 36% for older adults with mental health needs.

The five trusts with the greatest amount of dormitory provision were found to be:

1. Leicestershire Partnership NHS Trust – 166 beds on 39 wards
2. Greater Manchester Mental Health NHS Foundation Trust – 134 beds on 35 wards
3. Derbyshire Healthcare NHS Foundation Trust – 130 beds on 36 wards
4. Essex Partnership University NHS Foundation Trust – 76 beds on 18 wards
5. Sussex Partnership NHS Foundation Trust – 71 beds on 22 wards. [77]

Action 3: Mental health trusts to improve the therapeutic environment of inpatient wards by eliminating mixed sex accommodation; procuring en-suite facilities for all existing single rooms, improving the built environment to minimise the risks of harm; and making the estate more suitable for people with disabilities

Same-sex accommodation

All providers of NHS funded care are expected to eliminate mixed-sex accommodation to ensure the safety, privacy and dignity of patients is prioritised. Reporting breaches of the same-sex accommodation policy has been mandatory for providers since 2011.[78]

A breach will have occurred if:

- patients have to share sleeping accommodation with members of the opposite sex
- patients have to share toilet or bathroom facilities with members of the opposite sex
- patients have to walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms (this excludes corridors), and
- women do not have access to women-only day rooms in mental health inpatient units.

These current rules allow mixed corridors and other shared spaces on the same ward[79] but mental health providers should look for improvements that go further than the technical definition of same sex accommodation.

According to data obtained by the Health Service Journal in 2020, there were a total of 668 mixed sex wards and more than 803 mixed sex communal areas, from the 47 trusts that responded.[80]

NHSE/I advise that non-permanent structure changes to the estate can support the delivery of same sex accommodation where the partition is solid, opaque and floor to ceiling, and protects the privacy and dignity of the individual patient.[81]

En-suite facilities

Providing single rooms with en-suite facilities (including shower/bath, sink and toilet) will improve privacy and dignity during an inpatient stay. The 2018/19 Estates Return Information Collection (ERIC) confirmed there were 6,805 single rooms without en-suite facilities in mental health and learning disabilities sites across 58 NHS trusts and foundation trusts. This represents 36.7% of the 18,542 single

rooms available in those three types of site. By way of comparison, the proportion of single rooms without en-suite facilities across all other site types combined was 31.5% (11,774 of 37,338).[82]

18 of the 58 trusts mentioned above confirmed that at least 50% of their single rooms did not have en-suite facilities. The highest percentages in trusts with more than 50 single rooms were found to be:

1. Dudley and Walsall Mental Health Partnership NHS Trust – 98.5% (135 of 137)
2. Leeds and York Partnership NHS Foundation Trust – 82.3% (345 of 419)
3. Worcestershire Health and Care NHS Trust – 75% (69 of 92)
4. Oxleas NHS Foundation Trust – 71.9% (189 of 263)
5. South London and Maudsley NHS Foundation Trust – 67.7% (593 of 876).[83]

Action 4: Mental health providers to procure and/or develop property for clinical and office space for the Long Term NHS Plan expansion programme; alternative age-appropriate crisis care provision; age-appropriate mental health assessment spaces in A&Es and acute hospitals; and new mental health ambulances/transport vehicles

Clinical and office space

The LTP Mental Health programme aims to deliver high quality, evidence-based mental health services to an additional 2 million people.[84]An additional 27,460 staff working in mental health services, on top of the commitments from Stepping Forward (an objective of 19,000 additional staff by 2020/21) by 2023/24 will mean more office and workspaces will be required, predominantly in the community.[85] In addition to community office space, an expansion of community based clinical space will also be required. Both are crucial and the barriers to pathways of care which are a result of poorly designed or poorly procured clinical space in the community hinders both the quality and quantity of community-based treatment on offer.

Community mental health teams for adults, children and young people and older adults provide core mental health services. There are wide variations in the location, building sites, available room spaces in these teams nationally. The following considerations need to be given to all the community team bases:

- adequate space for holding clinical reviews, including facilities to organise physical health screening
- space and purpose-built rooms for group therapies, gym etc
- provision of telemedicine facilities to undertake video/remote review of patients
- space for staff meetings, in house training, reflective practice sessions and continuing professional development
- adequate car parking spaces for staff and patients using the site, and
- spaces ideally located close to the community as well as easy access to the primary care settings.

The COVID-19 pandemic has dramatically increased the need to embed technology into healthcare provision, with remote working and consultations becoming increasingly widespread across mental health services. Mental health providers should use the COVID-19 pandemic as an opportunity to improve patient care (e.g. choice) and workforce (increased flexibility) through digital technology and remote working. However, it is important that any new technology is thoroughly evaluated before it is implemented.

Office space is also required for research purposes. A clinical research culture improves patient outcomes, workforce satisfaction and retention alongside a significant contribution to the UK economy. Embedding research capacity within plans for infrastructural and service investment will be a productive strategy for best evidence-based practice.

Alternative crisis provision

The Independent Review of the Mental Health Act recommended that by 2023/24, investment in health-based places of safety should allow for the removal of police cells as a place of safety in the Act. This is subject to satisfactory and safe alternative health based places of safety being in place.[86]

There are currently very limited number of crisis houses or sanctuaries around England and this provision is not well documented.[87] NHSE/I require mental health providers to procure alternative forms of provision for those in crisis or requiring a mental health inpatient admission, such as sanctuaries, safe havens, crisis cafes or crisis houses.

It is important that any alternative crisis provision is age-appropriate and so for children and young people that should also include a range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways.

A comprehensive set of case studies on a range of crisis and acute mental health 'alternative' provision that complement traditional NHS crisis teams and acute inpatient services have been put together by NHSE/I.[88]

Assessment spaces in A&E and acute hospitals

A&E can be a stressful environment for any patient but particularly for those who are feeling paranoid, psychotic, distraught or suicidal.[89] According to the Psychiatric Liaison Accreditation Network (PLAN) at the College, a safe space should mean there are no ligature points, and nothing that can be used as a weapon. The room should have an alarm system and two doors that open both ways. It is not acceptable to use a room that doubles as an office. PLAN identifies that a patient may be observed in a different space to where they undergo assessment by the mental health team and departments should consider how they can make these spaces as safe, quiet, and calm as possible. A brief risk assessment of the environment should be made whenever a patient is at risk of self-harm is put in a cubicle. [90]

PLAN estimates that just 23% of type 1 A&Es (175 in total) meet their standards for physical environment. Having an assessment space that doubles as an office is the most common reason why a liaison service does not achieve full PLAN accreditation.[91] As such, there is a significant lack of psychiatric assessment rooms in many A&Es that are adequately equipped, which compromises patient safety and privacy.

During the pandemic, Mental Health A&Es were established over many parts of the country. According to the College's Faculty of Liaison Psychiatry, there is interest in maintaining alternative care pathways and facilities for patients who present with mental health problems, rather than them being assessed in traditional A&E. However, many such units have been created with limited planning and resources and are in facilities that are not fit for purpose in the long run. If this is to be the desired model in some parts of the country, longer term establishment of such units will require capital and revenue funding.

In acute hospitals there is rarely enough space to conduct clinics comfortably, so integrating psychological services into those clinics, even when a service has been commissioned to do so, can be almost impossible. There needs to be a mixture of dedicated space in a department of liaison psychiatry, and enough space in clinics, that patients can see a mental health professional as part of the integrated care they receive in that visit.

Mental health transport vehicles

There are a limited number of mental health transport vehicles across England and consequently, difficulties in the rapid and safe transport of patients between acute and mental health hospital sites. This has been highlighted further during the pandemic with the establishment of many standalone Mental Health A&Es and new diversion pathways.

Suitable transport vehicles need to be procured to reduce inappropriate ambulance conveyance or by police to A&E. For instance, Secure24 is an organisation that operates secure patient ambulance transport and support services and work with several mental health trusts, local authorities, the independent health sector and the police service. For persons of any age deemed to have a low to no risk, they offer a multi-person vehicle with two trained members staff and conference style seating making it easier for staff to monitor and attend service users, and there is a clear Perspex shield protecting the driver.

For persons of any age where the risk is deemed to be higher, they offer vehicles with three trained members of staff. The vehicles are designed to manage and support all levels of risk or complex needs and carry a range of equipment and PPE on board that staff can use to manage all types of situations. The ambulance design integrates sensory lighting, multi-media screens, support seating, climate control and seat harnesses that can be particularly helpful when supporting service users with learning disabilities or those who present with challenging behaviour. It also has an on-board cell that can significantly reduce the risk of violence, harm and escape.[92]

Secure24 currently work with Pennine Care NHS Foundation Trust, Southern Health NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust, Surrey and Borders Partnership NHS Foundation Trust, and Sussex Partnership NHS Foundation Trust, as well as local councils. [93] This highlights the existing demand for services of this nature.

While this service is likely to be funded through trusts' revenue budget, there is potential for local ambulance services to acquire similar types of vehicles within their fleet and provide a similar service to that of Secure24.

Action 5: Mental health trusts to replace ageing buildings

Age of the mental health estate

Almost one million square metres (981,091) of the mental health trust estate (based on 'gross internal site floor area', the 'total internal floor area of all buildings, occupied or unoccupied') was built before the NHS existed.[94] This represents 21.6% of the overall mental health trust estate, compared to 13.9% of the entire trust estate at that time (measured in terms of 'gross internal site floor area'). Other percentages by trust type are: acute non-specialist – 11.2%; specialist acute – 28.3%; community – 24.2%; and ambulance – 5.8%). Almost half of the mental health trust was built up to and including 1984 (2.142m square metres). At 47.2% this can be compared to 47.9% for the whole trust estate, or 62.2% for ambulance trusts, 55.2% for community trusts, 53.3% for acute specialist trusts and 47.1% for acute non-specialist trusts. [95]

The following mental health trusts were found to have the highest percentage of estate built before 1948 when figures were reported for 2014/15:

1. South West London and St George's Mental Health NHS Trust – 70.1%
2. Calderstones Partnership NHS Foundation Trust (NB – now part of Mersey Care NHS FT) – 54.0%
3. South London and Maudsley NHS Foundation Trust – 48.2%
4. West London Mental Health NHS Trust – 44.3%
5. Surrey and Borders Partnership NHS Foundation Trust – 42.0%[96]

‘Functionally unsuitable’ patient occupied areas

Another element of ERIC is the assessment of ‘patient occupied floor area’ deemed to be ‘not functionally suitable’ (defined as ‘below an acceptable standard, or unacceptable in its present condition, or so below standard that nothing but a total rebuild will suffice’). [97]

In 2018/19, out of 315 Mental Health (including specialist services) sites, 10 had 100% ‘patient occupied floor area’ assessed as ‘not functionally suitable’ (almost half of the 21 across all site types in England), 20 had 50% or more, 41 had 25% or more, and 56 had 10% or more. If other mental health and learning disability site types are added, then of 395 sites, 10 would be 100% ‘not functionally suitable (2.5% of all sites), 21 would be 50% or more (5.3% of sites), 42 would be 25% or more (10.6%) and 62 would be 10% or more (15.7%).

By comparison the numbers for general acute, out of 223 sites, were 0 at 100%, 16 at 50% plus (7.2%), 48 at 25% plus (21.5) and 80 at 10% plus (35.9%) and for community hospitals, out of 222 sites, were 10 at 100% (4.5% of sites), 19 at 50% plus (8.6%), 26 at 25% plus (11.7%) and 36 at 10% plus (16.2%).[98]

Action 6: NHS trusts to clear the high and significant risk maintenance backlog in mental health and learning disability services

The four categories of maintenance backlog are defined as below:

- High risk is defined as where repairs/replacement must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.
- Significant risk is defined as where repairs/replacement require priority management and expenditure in the short term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- Moderate risk is defined as where repairs/replacement require effective management and expenditure in the medium term through close monitoring so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- Low risk is defined as where repairs/replacement require to be addressed through agreed maintenance programmes or included in the later years of an Estates Strategy. [99]

Backlog is reported by both trust and site type.[100]

Site type – mental health and learning disability

For site type, in 2018/19, the total high-risk backlog across the three mental health and learning disability site types amounted to £12,879,428, which represents a 4.7% increase on 2017/18 (£12,295,447) but a 158.4% rise on just two years earlier (£4,984,567). While significant risk backlog declined by 8.0% in 2018/19 (£77,041,125) compared to 2017/18 (£83,718,926), it also remained 37.3% above the level of 2016/17 (£56,096,230).

Trust type – mental health trusts

When looking at this analysis by trust type, in 2018/19 the total high-risk backlog across mental health trusts amounted to £22.593m, which represents a 14.1% increase on 2017/18 (£19.804m) or 47.5% more than 2016/17 (£15.314m). There is a caveat that Midlands Partnership NHS Foundation Trust was formed in 2018/19 from a merger of a mental health trust (South Staffordshire and Shropshire Healthcare NHS Foundation Trust) and a community trust (Staffordshire and Stoke on Trent Partnership NHS Trust). If the

high-risk backlog from the latter is excluded from the calculation, the increase in 2018/19 compared to the previous year is still 9.9% (£21.774m is the revised total) or 42.2% compared to 2016/17.

Adopting the same approach to the significant risk backlog, the total in 2018/19 (£121.308m) is a mere 1.5% up on 2017/18 (£119.538m) but 40.0% more than 2016/17 (£86.656m). [101]

It is not possible to completely separate infrastructure backlog pressures from capital investment as if providers were to address their ageing estate through a rebuild programme, then this would also address the critical maintenance backlog. More than half of the high and significant risk backlog in mental health settings combined is found in only five trusts:

- South West London and St George's Mental Health NHS Trust – £34.734m, 24.04%
- South London and Maudsley NHS Foundation Trust – £13.065m, 9.04%
- Barnet, Enfield and Haringey Mental Health NHS Trust – £9.655m, 6.68%
- Coventry and Warwickshire Partnership NHS Trust – £9.178m, 6.35%
- Dorset Healthcare NHS Foundation Trust – £6.467m, 4.48%.[102]

Recommendations for Government and NHS national bodies

In order for NHS mental health providers and CCGs to meet the six actions outlined previously, Government, DHSC and NHSE/I must commit to the following recommendations and areas of investment. Detailed costings are provided in Table 1.

1. By 2024/25, DHSC and NHSE/I to provide a ring-fenced investment of **£3.34bn** (in current prices) to NHS mental health trusts (in addition to their day-to-day capital budgets) so they can, in the short-term reconfigure their existing estate through refurbishment, alterations and extensions to ensure mental health services are prepared and resilient to prevent nosocomial transmission of COVID-19 in these settings, and in the medium to longer-term, invest in transformational capital projects. This could be spread between COVID-19 costs, system-level allocations, and nationally allocated funding streams. When taking this proposed ring-fence investment of £3.34bn on top of mental health trusts' day-to-day capital budgets (based on trust budgets for day-to-day spending being at least maintained in current prices), the total investment over this period would equate to **£4.4bn**.

   Specifically, our proposed ring-fenced investment could be funded from the recently announced capital injection for 2020/21 as well as the investment to be announced in the 2020 CSR (recommendations 2 and 3 below).

2. Of the £1.5bn nationally allocated capital funding for 2020/21, DHSC and NHSE/I to allocate and ring-fence a total **£375.9m** (25.1%) to mental health NHS trusts to meet the following commitments during this financial year:

   a. <u>NHS critical maintenance and emergency/A&E capacity</u> (£100.9m [9.6%] of £1.05bn total allocation)
      - £68m to enable NHS mental health trusts to urgently reconfigure their existing estate in response to the COVID-19 pandemic, including acquiring temporary facilities (if required). NHSPS Taskforce should support mental health trusts leaders where necessary to procure and/or reorganise their estate as required
      - £12.9m to eradicate current high-risk maintenance backlog across mental health and learning disability sites/estates, and
      - £20m to begin to procure mental health ambulances/transport vehicles; create age-appropriate mental health assessment spaces in A&Es (or alternative) and acute

hospitals; and begin to procure alternative forms of age-appropriate mental health crisis provision.

b. Modernising the mental health estate (£250m total allocation)
    - £250m to begin to eliminate dormitory provision and replace with single en-suite rooms.
c. Health Infrastructure Plan (£200m total allocation)
    - £25m of seed funding for the first five new major building and redevelopment schemes in mental health trusts. Decisions about which NHS trusts should be prioritised for seed funding for HIP projects should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads – potential trusts are detailed in the endnote. [103]

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

3. At the 2020 CSR, the Government, DHSC and NHSE/I to provide a ring-fenced investment of an additional **£2.96bn** to mental health NHS trusts between 2021/22 and 2024/25 as part of a multi-year capital settlement. This additional capital funding uplift should be in addition to trusts' day-to-day capital budgets and building on the momentum and previous targeted investment for 2020/21 as outlined above (recommendation 2). This investment should include:

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

        - £510m for the first instalment of a new £1bn building and redevelopment programme for Mental Health to enable six major building and redevelopment schemes to be awarded to mental health NHS trusts by 2024/25 (building on the proposed £25m of seed funding from 2020/21 and inclusive of a further £5m of seed funding for the sixth scheme), and with a commitment to deliver a further six mental health building and redevelopment schemes by 2030 (inclusive of a further £35m of seed funding). Decisions about which NHS trusts should be prioritised for seed funding should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads – potential trusts are detailed in the endnote[104]
        - £800m to improve the therapeutic environment of mental health and learning disability/autism inpatient settings by: eliminating mixed sex accommodation; procuring en-suite facilities for all existing single rooms; minimising the risks of harm through innovative safety improvement projects, and making the estate more suitable for people with disabilities
        - £350m to complete the elimination of dormitory provision and replace with single en-suite rooms
        - £600m for new building and redevelopment schemes for community mental health facilities, including clinical and office space, in order to deliver the confirmed objectives of the LTP up to 2023/24 and the expected further expansion of services in the remaining period
        - £100m for new building and redevelopment schemes for crisis mental health facilities, including the procurement of mental health ambulances/ transport vehicles; creating age-appropriate mental health assessment spaces in A&Es (or alternative) and acute hospitals; and procuring age-appropriate alternative forms of mental health crisis provision – building on the proposed investment of £20m during 2020/21.
        - £30m of capital funding for drug and alcohol use disorder services[105]

- £250m to improve digital technology within mental health trusts, and
- £160m for Research and Development in Mental Health and Dementia.

b. £160.88m to eradicate current significant and moderate risk maintenance backlog in mental health and learning disability sites/estates.

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

5. NHSE/I and ProCure22 to provide a tailored package of support so that the six sites selected for the initial wave of the building and redevelopment programme for Mental Health can reach the stage of full business case approval by 2024/25.

6. Within the existing HIP programme, or where investment is being made for a new or upgraded acute hospital, DHSC, NHSE/I and local leaders to consider whether plans include sufficient space for integrated mental and physical healthcare (liaison mental health services) to be delivered. This needs to be built into service design from the outset.

7. DHSC and NHSE/I to account for any pre-existing strategic capital schemes within their system-level capital allocations for the next financial year and beyond in order to avoid inadvertently reducing the capital funding available to individual trusts as a consequence. NHSE/I and DHSC should also make the formula used to calculate system-level capital budgets more transparent.

8. NHSE/I to ensure governance structures and accountability requirements for ICSs are more robust, given the move to shared decision making and negotiations between system partners for capital and estates planning and funding, with any arising issues resolved consistently across all systems.

9. NHSE/I and NHSD to require all providers of NHS mental health services to report an assessment of their current estate and report on their key gaps, risks and pressures and their contingency through a one off data collection exercise in response to the COVID-19 pandemic by 2020/21 year-end. This needs to include the community clinical estate as well as inpatient and crisis environments. This exercise should align with existing reporting mechanisms to reduce the burden on providers.

10. CQC and NHSE/I to extend their Use of Resources (UoR) assessment[106] to mental health providers, as this considers the value of trusts' backlog maintenance and how effectively it is managed; how efficiently the trust is using its estate and maximising the opportunity to release value; and the estates cost per square meter.[107]

11. NHSE/I and the CQC to extend the definition of mixed sex accommodation to include corridors and other shared spaces on the same ward.

12. All mental health trusts to adopt the sexual safety standards developed by the National Collaborating Centre for Mental Health and commissioned by NHSE/I by 2023/24.

13. As part of a Government-led Mental Health Safety initiative, NHSE/I to support mental health trusts so that 60% will be rated as good or outstanding on safety by 2023/24 and 75% by 2028/29 – an improvement from 47.1% in July 2020. CQC should also resume its normal functions as soon as possible and reintroduce a national mental health inpatient services experience survey to provide critical insight into people's experiences on inpatient wards during the pandemic and beyond.

Costings

The proposed mental health capital investment programme covers the following:

- COVID-19 Mental Health Response Fund
- Health Infrastructure Plan (HIP) for Mental Health, and
- backlog maintenance costs across mental health and learning disability sites.

This proposed investment is in addition to day-to-day capital spending for NHS mental health trusts. For example, in 2018/19, mental health trusts spent £255.28m on equipment, maintaining their existing estate, and ongoing backlog maintenance issues.[108]

Table 1. Mental health capital investment programme – investable propositions for 2020/21-2024/25 and beyond

MENTAL HEALTH CAPITAL INVESTMENT PROGRAMME	PROJECT	TYPE OF CAPITAL INVESTMENT	COST (£M)	INVESTMENT PERIOD	SOCIETAL BENEFITS	ECONOMIC BENEFITS
COVID-19 Mental Health Response Fund (Action 1)	Reconfiguration of the existing mental health estate in response to pandemic, including acquiring temporary facilities (if required)	Public capital/ CDEL	~£68	2020/21	Reduced nosocomial transmission of COVID-19 Providing safe space for patient and enabling discharge planning to be driven by recovery trajectory, as opposed to risk of nosocomial infection Improved safety of staff by providing sufficient space to don and doff PPE, practice infection	Reduced staff sickness and absence

					prevention and control with procedures in place for vulnerable groups Reduced staff stress and sickness absence	
Health Infrastructure Plan (HIP) for Mental Health – to include longer-term assets that support the NHS' delivery of world-class mental healthcare and the accompanying healthcare infrastructure that supports mental health outcomes (Actions 2-5, Objective 1, and Actions 3 and 5, Objective 2)	12 new major building and redevelopment projects for mental health facilities	Public capital/ CDEL, private capital, fully serviced occupancy	£1,000, of which: ▪ £510 is committed by 2024/25 (building on £25m of seed funding in 2020/21) ▪ £465 by 2030 (inclusive of £30m seed funding)	▪ 6 hospitals/ schemes to be delivered by 2024/25 ▪ 6 hospitals/ schemes to be delivered by 2030	Improved therapeutic environment with more open space, improved access to outside gardens and safe places for family/friends/carers to meet will support recovery Ability to deliver joined up care in communities with NHS, council and voluntary and community organisations Reducing out of area placements, meaning patients can stay closer to home and their friends and family Improved staff health and wellbeing and improved staff satisfaction Increased morale and retention of staff Improved environmental impact and sustainability	Increased staff productivity Reduced agency staff costs Reduced turnover of staff Fewer out of area placement bed days

	Improve the therapeutic environment of mental health and learning disability/autism inpatient settings by: ▪ eliminating mixed sex accommodation ▪ procuring en-suite facilities for all existing single rooms ▪ minimising the risks of harm through innovative safety improvement projects, and ▪ making the estate more suitable for people with disabilities.	Public capital/ CDEL	~£800	2021/22 to 2024/25	Enhanced privacy and dignity Improved patient experience and outcomes Improved equity of access Improved accessibility for patients with disabilities	Reduced length of stay Reduction in readmission rate
	Eliminate dormitory provision and replacing with single en-suite rooms	Public capital/ CDEL	£600 ▪ £250 by 2020/21 (already committed) ▪ £350 by 2023/24	2020/21 to 2023/24	Enhanced privacy and dignity Improved patient experience Improved patient outcomes	Reduced length of stay
	New building and redevelopment schemes for community mental health facilities including clinical and office space	Public capital/ CDEL, private capital, fully serviced occupancy	~£600	2021/22 to 2024/25 ▪ £450 up to and including	Well procured clinical space in the community improves both the quality and quantity of community-based treatment on offer	Widened access to services provides more people with support and helps to reduce

				2023/24 to align with LTP expansion programme ▪ £150 is assumed for 2024/25 for ongoing expansion.	Sufficient space for health professionals to assess and treat patients Patients not having to travel far away from their home	economic cost of mental illness
	New building and redevelopment schemes for crisis mental health facilities, including: ▪ alternative forms of age-appropriate provision for those in crisis or requiring a mental health inpatient admission e.g. health-based places of safety, sanctuaries, safe havens, crisis cafes and crisis houses ▪ age-appropriate assessment spaces in A&E and acute hospitals for people with mental health/learning disability needs, and ▪ new mental health ambulances/ transport vehicles to reduce inappropriate ambulance or police conveyance to A&E.	Public capital/ CDEL, private capital, fully serviced occupancy	~£120, of which: ▪ ~£90 for crisis alternatives [109] ▪ ~£20 for A&E/acute mental health spaces [110] ▪ ~£10 for mental health ambulances [111]	2020/21 to 2023/24 ▪ £20m during 2020/21 ▪ £100m during 2021/22 – 2023/24	Improved patient outcomes Better patient experience Reduced use of A&E Reduced hospital admissions	Reduced use of A&E Reduced hospital admissions

	Capital funding for drug and alcohol use disorder services[112]	Public capital/ CDEL, private capital	~£30	2021/22 to 2024/25	Improved quality and availability of drug and alcohol use disorder services Improved therapeutic environment Ability to deliver joined up care in communities with NHS, council and voluntary and community organisations Improved staff health and wellbeing and improved staff satisfaction Increased morale and retention of staff	Reduced A&E presentations
	Improving digital technology within mental health trusts by: ▪ improving IT infrastructure ▪ expanding the Global Digital Exemplar programme to other mental health trusts ▪ expanding the Digital Aspirant programme to other mental health trusts, and ▪ developing a new Mental Health Innovation Fund.	Public capital/ CDEL, private capital	~£250 including: ▪ £135 (IT infrastructure) ▪ £50 (GDEs) ▪ £15 (Digital Aspirant funding) ▪ £50 (new Mental Health Innovation Fund)	2021/22 to 2024/25	Improved patient choice Improved patient outcomes Improved staff satisfaction	Improved staff productivity Fewer missed appointments Increase in staff retention

	Research & Development in Mental Health and Dementia, including: ▪ the prevention agenda ▪ research to improve the productivity and effectiveness of the NHS, and ▪ the translation of basic science and support for the life sciences industry.	Public capital/ CDEL	~£160 [113]	2021/22 to 2024/25	Improved research facilities and support services Encouraging innovation and research into mental health, learning disabilities, autism and dementia Support for clinical academics in psychiatry	Further preventative interventions identified More effective and efficient treatments identified
Backlog maintenance (Action 6)	Eradicate high and significant risk backlog maintenance	Public capital/ CDEL	Combined high, significant and moderate: £173.759239 ▪ High risk: £12.879428 ▪ Significant risk: £77.041125 ▪ Moderate risk: £83.838686 [114]	2020/21 to 2024/25 ▪ addressing high risk in 2020/21 ▪ significant risk between 2021/22 and 2022/23, and ▪ the current moderate risk by 2024/25.	Patient and staff safety Improved CQC ratings for safety Improved staff morale and retention Enhanced privacy and dignity Improved patient experience and outcomes Improved equity of access	Reduced agency costs Reduction in liability costs Reduced length of stay Reduction in readmission rate
TOTAL		**£3,801.76m** **Investment by 2024/25: £3,336.76m** **on top of day-to-day capital spending of an estimated £1,021.12m (based on 2018/19 figures), totalling £4,357.88m** **Investment to support ongoing HIP schemes up to 2030: £465.0m**				

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[98] Ibid.
[99] Ibid.
[100] Three site type categories include:
(i) Mental Health (including Specialist Services) - sites exclusively providing mental health services including specialist mental health services e.g. secure units.
(ii) Learning Disabilities - sites exclusively providing learning disabilities services
(iii) Mental Health and Learning Disabilities - both mental health and learning disabilities provided from the same site by the same provider. No Acute/Specialist or Community services will be provided.
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[103] Decisions about which mental health trusts should be prioritised for seed funding for HIP projects should be determined by the Mental Health and Learning Disability/Autism team at NHSE/I, working alongside regional mental health leads. Without wishing to presume the outcomes of those discussions, we have identified some trusts that might benefit from capital transformation funding in particular given the age of their estate or a poor CQC safety rating. These trusts include:
Inadequate for Safety (acute wards: working age adults and psychiatric intensive care)

1. Bradford District Care NHS Foundation Trust
2. Lancashire and South Cumbria NHS Foundation Trust
3. Leicestershire Partnership NHS Trust
4. Nottinghamshire Healthcare NHS Foundation Trust
5. Sheffield Health and Social Care NHS Foundation Trust

Ageing estate (NB - As of most recent data in 2015, in order of highest proportion of estate built before 1948)

6. South West London and St George's Mental Health NHS Trust
7. South London and Maudsley NHS Foundation Trust
8. West London NHS Trust
9. Surrey and Borders Partnership NHS Foundation Trust
10. Devon Partnership NHS Trust
11. Oxford Health NHS Foundation Trust
12. Kent and Medway NHS and Social Care Partnership Trust

[104] Ibid.
[105] This is on top of the Public Health Grant funding to expand drug and alcohol use disorder services.
[106] CQC and NHS Improvement now report and rate use of resources (UoR) for non-specialist acute trusts. These assessments are carried out by a team from NHS Improvement who provide their findings to CQC in order for CQC to write the assessment report and decide a trust's UoR rating for use of resources. This rating is then combined with CQC's existing five quality ratings for the trust.

[107] NHS Providers. **Regulation Survey 2019. Care Quality Commission. Use of Resources.** 2019. Available from: https://nhsproviders.org/regulation-survey-2019/care-quality-commission [Accessed 15 July 2020].
[108] NHS Digital. **Estates Return Information Collection – England, 2018-19.** October 2019. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2018-19 [Accessed 18 June 2020].
[109] Indicative modelling based on the costs of existing crisis houses scaled up for national coverage.
[110] High level estimate based on indicative information from the Psychiatric Liaison Accreditation Network (PLAN) at the RCPsych. However, Mental Health A&Es were established across the country during the pandemic and many have been created with limited planning and resources and are in facilities that are not fit for purpose in the long run. If this is to be desired model in some parts of the country, longer term establishment of such units will require capital and revenue funding.
[111] Indicative modelling based on the costs of the South West Ambulance model and scaled up for national coverage.
[112] This funding is on top of a subsequent recommendation for a real terms increase in the Public Health Grant budget to fund drug and alcohol use disorder services.
[113] This recommendation covers only the NIHR Biomedical Research programme, currently funded up to 2021. Additional funding streams would also be required to support delivery of the objective to double the proportion of research funding devoted to mental health and dementia by 2030.
[114] NHS Digital. **Estates Return Information Collection – England, 2018**-1 [Accessed 18 June 2020]. October 2019. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2018-19 [Accessed 18 June 2020].