



National Audit Office



REPORT

# Progress in improving mental health services in England

Department of Health & Social Care

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## Key facts

**4.5mn**

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

**£12.0bn**

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

**4.9 times**

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

**22%  
(24,000)**

increase in NHS mental health workforce between 2016-17 and 2021-22

**44%**

increase in referrals to NHS mental health services between 2016-17 and 2021-22, from 4.4 million in 2016-17 to 6.4 million in 2021-22

**8 million**

NHS England estimate of the number of people with mental health needs not in contact with NHS mental health services, as of 2021

**1.2 million**

estimated number of people on the waiting list for community-based NHS mental health services at the end of June 2022

**26%**

estimated proportion of 17- to 19-year-olds with a probable mental disorder in 2022, increasing from 10% in 2017

**17%**

proportion of NHS mental health funding spent on non-NHS providers, including independent and voluntary sector providers, in 2021-22

**61%**

for July to September 2022, proportion of referrals to talking therapy services excluded from calculation of waiting time standards

# Summary

## Introduction

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

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

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

## Scope of the report

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

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

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

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

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

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

## Key findings

### Improving services for patients

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

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

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

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

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

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

## Increasing mental health service workforce, funding and information

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

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

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

Achieving parity of esteem

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

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



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

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

## **Conclusion on value for money**

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

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

## **Recommendations**

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

- a** DHSC and NHSE should publish a detailed statement of what achieving full 'parity of esteem' between mental and physical health services encompasses, in terms of access and service standards, staffing model and funding allocations, and the road map for national bodies, ICBs and local providers to achieve it.
- b** Either separately or as a distinct part of the overall NHS workforce plan due in 2023, DHSC and NHSE should publish a longer-term mental health workforce recruitment and retention strategy and a costed plan, that reflects the volume and skills required to meet future service ambitions. They will need to engage closely with HM Treasury in this process. The strategy should include how they will work with ICBs on local workforce development, recruitment and retention.
- c** NHSE, working with local ICBs and providers, should improve its data and analysis to better understand the relative cost and cost-effectiveness of different services, and provide a more robust basis to decide future priorities.
- d** NHSE, working with ICBs, should develop and issue guidance in 2023 on how the system will gain more transparency over capacity, activity, performance and outcomes in community mental health services, including improvements required to implement the proposed new clinical standards, as well as mental-health- related capacity and activity in primary care.
- e** As mental health services will need to remain the focus of sustained improvement and in the light of the national and local reorganisation of health bodies, DHSC and NHSE should set out the future approach to leading, monitoring and assuring oversight of mental health service expansion and improvement. This should include how they ensure that ICBs and NHS providers have sustainable plans for workforce and service models in the short to medium term.