



FUNDING  
MENTAL HEALTH  
AT LOCAL LEVEL  
UNPICKING  
THE VARIATION

# FUNDING MENTAL HEALTH AT LOCAL LEVEL

## UNPICKING THE VARIATION



*Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase.*

**Delivering the NHS Five year forward view:  
NHS planning guidance 2016/17 - 2020/21**

## EXECUTIVE SUMMARY

Since 2012, there has been a sustained focus at national level to address the lack of parity between mental and physical health services. We have seen the introduction of mental health access standards, a commitment to improve child and adolescent services, the mandatory provision and expansion of liaison psychiatry services in acute settings, and the establishment of the Crisis Care Concordat to drive local collaboration and improvement in mental health crisis care.

Most recently, in February 2016, the final report of the mental health taskforce set out a 10-year strategy for transforming NHS mental healthcare, with 58 far-reaching recommendations to help cement existing initiatives and ensure a more coordinated approach – especially to prevention, early intervention and access.

This sustained policy focus on mental health has been long overdue and is welcomed by the sector, but unless supported by a policy and funding framework which enables local organisations to invest in services, parity of esteem will not be realised 'on the ground'.

Since 2015, commissioners have been required to increase spending on mental health services at least in line with the amount by which their allocation – the money available to buy local services – has increased. In 2016/17 this was an average increase of 3.4%.

In March 2016, NHS Providers and the Healthcare Financial Management Association (HFMA) partnered to survey providers and commissioners to find out how this commitment is being implemented locally. More than half of mental health trusts responded to the survey, along with 10% of clinical commissioning groups (CCGs). We found that parity of esteem is not yet being realised consistently at the local level and concerted efforts will be required to ensure that progress is made during 2016/17 and beyond. While providers are not necessarily seeing increased investment, commissioners believe they are meeting requirements through investment in a broader range of services.

- Only half (52%) of providers reported that they had received a real terms increase in funding of their services in 2015/16.
- A higher proportion of providers received a real terms increase from CCGs than from NHS England teams in 2015/16. Only five respondents reported that both their lead CCG and NHS England commissioners had increased their investment in line with growth in budget allocations.
- Only a quarter (25%) of providers were confident that their commissioners were going to increase the value of their contracts for 2016/17.
- There is a lack of alignment between commissioners and providers over what it means to implement parity of esteem – there is confusion over what services should be covered, and how much investment should be made.
- Over 90% of providers and 60% of commissioners were not confident that the £1 billion additional investment recommended by the mental health taskforce and supported by NHS England will be sufficient to meet the challenges faced by mental health services.
- The policy and funding framework does not currently support providers and commissioners to invest in mental health services and to make required service improvements and transformation.

We need to move beyond simply calling for parity of esteem, to a more sophisticated understanding of where the barriers remain and what can be done to address them. The findings from this survey are intended to shed light on what is happening on the ground between commissioners and providers and to offer recommendations for improvement.

NHS Providers and the HFMA believe that four things need to happen if we are to better support NHS organisations to meet their parity of esteem commitments over the course of this parliament:

- 1 Clarity from the government and system leaders about how much is being made available for mental health services, and in which areas.
- 2 Explicit alignment is needed about what it means to meet parity of esteem commitments.
- 3 Better support for local organisations.
- 4 Greater transparency across the system about how much is being spent on mental health services.

## ABOUT THE SURVEY

In March 2016, NHS Providers and the HFMA's Mental Health Finance Faculty surveyed finance directors from the 58 NHS foundation trusts and trusts across England that provide mental health services. We asked about the contracts they had in place for 2015/16, how confident they are that they will see increases in funding of their services in 2016/17, and their perceptions about the feasibility of meeting recommendations made by the mental health taskforce in the current context.

Responses were received from 32 NHS providers of mental health services (55% of the sector), representing a mix of standalone mental health providers and integrated providers of mental health and community services. Please note that not all the questions were answered by all respondents, and the response rate varies across different questions.

The HFMA also surveyed chief finance officers from CCGs, through its Commissioning Faculty. Responses were received from 21 CCGs (10% of the sector). Although this is a relatively small sample of CCGs, the results have provided an opportunity to highlight the issues also faced by commissioners in making parity of esteem a reality for their local populations. Again, not all the questions were answered by all respondents, and the response rate varies across different questions. NHS England specialised teams were not surveyed as part of this project.

Providers and commissioners were given mirror surveys to respond to, but there were more questions for providers which accounts for why there are more findings in this report related to NHS trusts.

At the time of surveying, only a very limited number of contracts had been agreed for 2016/17. As such, the findings highlighted in this briefing in relation to 2016/17 provide a picture from our members about the likely direction of travel as of the end of March 2016, but this might change in their final contracts. It also provides a platform to conduct a further analysis in 2016/17 drawing on the results received on this occasion.

# FINANCIAL CONTEXT

It is widely recognised that the necessary improvements in mental health services will be difficult to make or sustain unless adequate funding is made available. Over the past two years, a number of new funding streams have been announced, including:

- £600 million funding for mental health as announced in the autumn statement for 2015/16
- £1.25 billion for children and young people's mental health services to 2020/21
- £1 billion to implement the recommendations from the mental health taskforce over the course of the parliament.

This combination of new policy and additional funding should have created a framework to support local areas prioritise resources for mental health services. However, in many local areas this is not yet being realised on the ground with a direct impact on patients and service users.

Additional funding is welcome and necessary, but it needs to be accompanied by sufficient detail about how the additional investment will reach frontline services or which mental health services – including perinatal mental health, talking therapies and crisis care – will be prioritised.

For example, it is not clear whether the £1 billion announced to implement the taskforce's recommendations is a real or cash terms increase, made on a recurrent or non-recurrent basis. In addition, is it cumulative and/or is it intended to come out of existing funding streams, similar to the approach adopted with the introduction of the better care fund (BCF). This lack of clarity both inhibits commissioners from prioritising resources for mental health services and undermines providers' attempts to improve frontline services for patients and service users.

There is also a distinct lack of clarity and consensus about what, from a local commissioning perspective, can be reasonably considered 'mental health services'. This in turn has led to confusion between commissioners and providers about how to interpret parity of esteem, and has created an element of mistrust between organisations.

These concerns are playing out against a backdrop of a wider crisis in NHS finances. Half of all mental health NHS foundation trusts and trusts are now in deficit, and 75% of all providers are in deficit overall.

Pressure is also mounting on CCGs. When the HFMA surveyed chief finance officers in November 2015 (as part of its bi-annual financial temperature check), more than 56% of CCG chief finance officers reported their forecast 2015/16 end of year position was worse than their organisation's 2014/15 financial position.<sup>1</sup> Although we await the final results for 2015/16, all indicators are that this position has worsened and that 2016/17 will be just as challenging if not more so.

Addressing provider deficits for 2016/17 has been identified as a priority and sustainability funding will be made available this year, but this is targeted at acute rather than mental health providers as this is where most deficits are concentrated.

Even those providers still in good financial health have been asked to play their part in supporting the overall financial position of the sector, offsetting their surpluses to mitigate the overall provider financial position. All providers have also been asked to sign up to a financial target this year, which sets a maximum deficit or minimum surplus position – this will understandably focus minds on financial targets, rather than creating an environment in which investment in key areas can be made.

CCGs have also been asked to improve their financial positions where possible – for example, those commissioners in surplus have agreed to meet a larger surplus by the year-end.<sup>2</sup>

These tensions are putting substantial pressure on the contracting round for 2016/17 – commissioners are facing many competing demands on their resources, and the knock-on impact could be that less is invested in mental health this year, even to meet current levels of demand let alone invest in new services.

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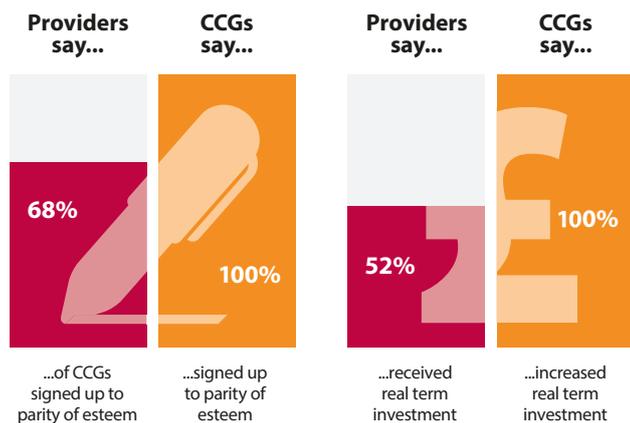
1 NHS Financial Temperature Check, the HFMA, November 2015  
2 It should be noted that CCGs work under a different financial regime to NHS foundation trusts and trusts, which makes direct comparison of their financial performance difficult. CCG financial performance is reported against what was planned and business rules set out by NHS England apply. CCG allocations include their brought forward surplus or deficit positions, and the plan will include agreed changes to the brought forward position. NHS foundation trust and trust performance is based on in-year income and expenditure.

# FINDINGS

## Are commissioners meeting their commitments to parity of esteem?

THE MAJORITY OF COMMISSIONERS HAVE SIGNED UP TO THE PRINCIPLE OF PARITY OF ESTEEM BUT THIS DID NOT NECESSARILY FOLLOW THROUGH IN TERMS OF INVESTMENT TO PROVIDERS LAST YEAR

Our survey reveals that over two thirds (68%) of providers reported that their lead CCG had signed up to the principle of parity of esteem, but only around half (52%) indicated that they had received a real terms investment in their 2015/16 contracts in line with the growth in commissioner allocations.



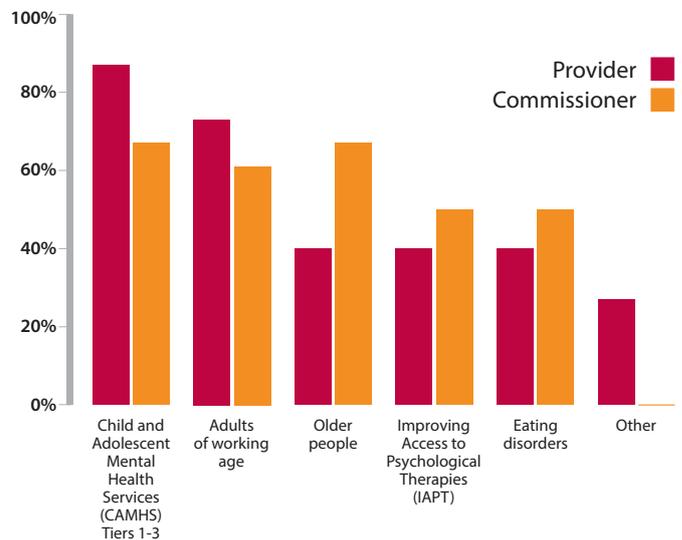
All CCGs responding to the survey indicated that they had signed up to the principle of parity of esteem and had increased their real terms investment in mental health services in line with the planning guidance requirement.

Where investment was made, providers reported that it was accompanied by additional service requirements, in particular the implementation of the new access and waiting standards which was a requirement under the NHS Mandate. The majority of respondents (79%) also highlighted that investment was made once providers could demonstrate how and when it would be spent (referred to as evidence of spend).

Eighty per cent of trusts highlighted that the investment was also accompanied by additional reporting requirements or data collections. One finance director indicated that their commissioners were requesting 'detailed monthly reporting of all invested schemes, including those that were just £20,000 recurrent investments'.

The most common areas for additional investment last year were: child and adolescent mental health services (CAMHS) tiers 1-3, adults of working age and older people services. Figure 1 highlights that these were common priorities for respondent providers and CCGs.

**Figure 1:** Services in which additional investment was made in 2015/16 (CCG commissioned services only)



In many of the qualitative comments from providers and CCGs, funding pressures on commissioners were cited as a key reason for investment not being as expected. One provider finance director highlighted that their trust has 'three lead commissioners who have taken different approaches due to their financial position... some have invested [in mental health services] and others have not.'

Commissioners also cited conflicting messages over how they should be responding to these pressures. For one CCG in financial recovery, improving the financial position was the priority over and above increasing investment in mental health services.

## COMMITMENTS TO FUND THE MOVE TO PARITY OF ESTEEM DIFFER BETWEEN CCGs AND NHS ENGLAND LOCAL TEAMS

Last year NHS Providers reported that mental health trusts were more confident that they were going to receive a real terms investment from CCGs for local mental health services than they were from NHS England area teams for specialised mental health services.<sup>3</sup> This continues to be a theme in this year's survey.

Of the respondents which have contracts in place with NHS England, only a third (32%) said that they had received a real terms investment in mental health services in 2015/16 and only a quarter (24%) said that their NHS England team had signed up to the principle of parity of esteem. Only five providers (21%) reported that both their contracts with NHS England and lead CCG had received real terms investment.

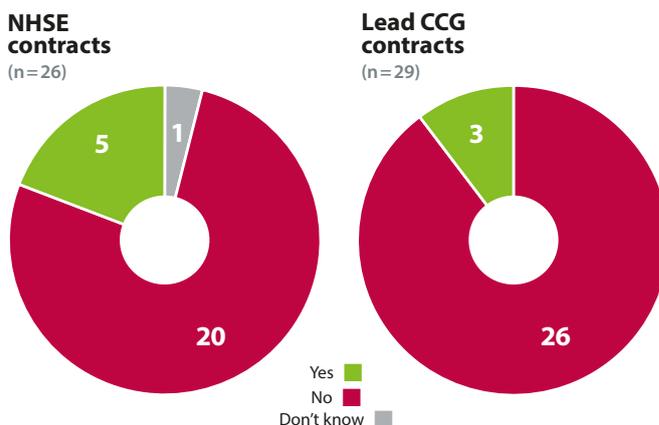
### THE SITUATION DOES NOT APPEAR TO BE IMPROVING IN 2016/17, WITH THE MAJORITY OF PROVIDERS NOT CONFIDENT THAT THEY WILL RECEIVE A REAL TERMS INCREASE IN THEIR SERVICES

At the time of surveying, only around 20% of providers indicated that they had already agreed contracts with NHS England, and only 10% with their lead CCG (figure 2) which means that limited conclusions can be drawn at this stage.

It is concerning that the contracting round for 2016/17 is again protracted, taking place even later than last year. This level of uncertainty does not help either commissioners or providers to plan for the year ahead and ensure that resources can be allocated most efficiently to meet the needs of service users.

Of those yet to agree a contract, only a quarter (26%) were confident or very confident that their commissioners were going to increase their investment in mental health services in line with the allocation growth for 2016/17.

**Figure 2:**  
The number of contracts agreed for 2016/17 (according to provider respondents)



If this follows through in terms of signed contracts, this would represent a substantial reduction in investment in mental health services from 2015/16 in which half of providers reported an increase. This suggests that far from the situation improving, the progress towards implementing parity of esteem might actually be stalling or even going backwards.

Out of the six commissioners who had already agreed contracts for 2016/17, all indicated that they had made a real terms increase this year to support the delivery of access standards and waiting times. Of those yet to agree a contract, 92% of responding commissioners were confident that they were going to increase the investment in mental health services in line with their growth allocation for 2016/17.

It should be noted that the samples of commissioners and providers that responded do not necessarily correspond directly with each other.

<sup>3</sup> NHS Providers (2015) Funding for Mental Health Services: Moving Towards Parity of Esteem?

# What is preventing parity of esteem from being realised?

A number of themes emerge from the feedback to the survey, highlighting a lack of shared understanding about how parity of esteem can be demonstrated and realised. Many of these inconsistencies need to be clarified by system leaders at a national level so that local organisations are supported to invest more in mental health services.

## THERE IS A LACK OF ALIGNMENT BETWEEN COMMISSIONERS AND PROVIDERS OVER WHAT IT MEANS TO IMPLEMENT PARITY OF ESTEEM

Feedback to the survey clearly indicated a disjoint between commissioners and providers about whether the requirement in the planning guidance to increase the real terms investment in mental health services was being met. Commissioners highlight that they have invested in mental health services, and frontline providers argue that they have not always seen this investment.

At the heart of this issue appears to be what organisations ‘badge’ as mental health spend. According to respondents, commissioners might be investing in areas not provided by secondary care trusts, such as primary care, drugs, the mental health component of continuing healthcare, and out of area services. This means that commissioners might report that they have increased their spend on mental health services, while some providers will have seen no direct investment or, even in some cases, disinvestment.

One provider finance director indicated that ‘CCGs believe that this requirement only applies to net increase in growth allocation, not the total increase. They also include increased expenditure on learning and development services, A&E services (where an individual with a mental health diagnosis attends), and continuing healthcare payments as counting towards parity of esteem’.

Although this might explain differences between individual providers, it is concerning that investment priorities and funding are not currently aligned at a local level. There are mechanisms in place at a local level to secure better alignment, such as through health and wellbeing boards, and there are a number of positive

examples of how providers can be better involved and engaged in their work.<sup>4</sup> There is also an opportunity through the development of multi-year system-wide sustainability and transformation plans (STPs)<sup>5</sup> to ensure better joint planning and delivery of mental health services.

## CONFLICTING GUIDANCE IS HAMPERING EFFORTS TO FOLLOW THROUGH ON PARITY OF ESTEEM COMMITMENTS

Feedback to the survey highlights that it is difficult for local organisations to understand how payment rules interact with the planning guidance.

The national tariff is the payment system for the secondary care system, covering £70 billion worth of NHS spend. It is set annually by NHS England and NHS Improvement and determines the efficiency requirement and cost adjustments for prices and contracts across the sector. In 2015/16, prices and contracts were reduced by 1.6% – this is intended to be the starting point for discussions between commissioners and providers for locally priced services, such as mental health.

A number of respondents to the survey highlighted that their contracts were simply reduced by this amount, with little regard for the planning guidance requirement to increase investment.

For 2016/17, tariff prices and subsequently contracts are supposed to be increased by 1.8% to take account of a more reasonable efficiency requirement and cost uplift, but this is also difficult to interpret alongside parity of esteem requirements given that CCG budgets have been increased by an average of 3.4%.

This is leading to confusion at a local level about how this guidance is intended to interact with parity of esteem.

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4 NHS Providers, NHS Improvement and the Local Government Association

5 A five-year plan from October 2016 to March 2021 for the local health and care system. It is based on the local population and must reflect local health and wellbeing strategies.

## THERE IS A LACK OF PARITY ACROSS SECONDARY AND SPECIALISED MENTAL HEALTH SERVICES

There is on going uncertainty about whether NHS England as national commissioner of specialised mental health services is required to sign up to the principle of parity of esteem or follow the requirement in the planning guidance.

This sends a slightly conflicting message to local commissioning organisations. On the one hand NHS England is asking CCGs to support investment in mental health services, while on the other hand this is not consistently applied across its own specialised commissioning teams.

As we move towards more placed based allocations, planning and commissioning, it is essential that local and national commissioners are working to aligned objectives and priorities.

## COMMISSIONERS CONTINUE TO FACE COMPETING PRIORITIES AND FUNDING PRESSURES

The survey bears out that CCGs continue to face competing service pressures in 2016/17 which will have implications for how much of their resources can be dedicated to mental health services.

As in 2015/16, these include the ring-fencing of part of CCG allocations for direction into the BCF; inflationary pressures in relation to primary care contracts; continued pressures in acute services (both emergency and planned activity) and prescribing budgets; as well as increases in continuing healthcare costs.

Although the majority of CCGs will see a real terms increase growth in their allocations for 2016/17, this is not the case for all. Twenty-eight commissioners have had their allocations reduced in line with NHS England's pace of change policy. This means delivering material savings over and above those for 2015/16.

## Looking to the future: the mental health taskforce

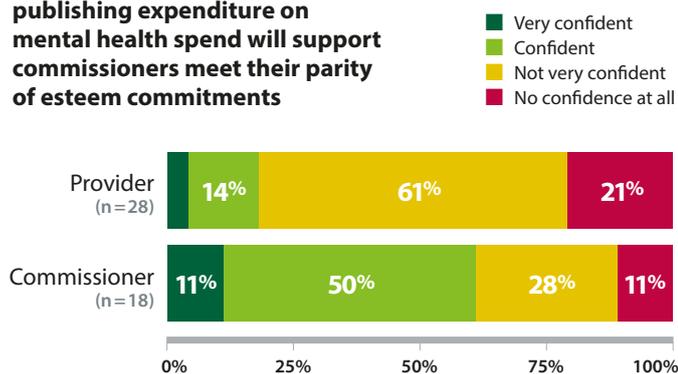
### GREATER TRANSPARENCY OVER MENTAL HEALTH SPENDING WILL NOT BE SUFFICIENT TO DELIVER PARITY OF ESTEEM

The mental health taskforce identified commissioning as the most critical system level factor for building stronger foundations for high quality mental healthcare. However, at present there is a two-fold difference in apparent per capita spend on mental health by CCGs across England, high fragmentation of services due to the split of commissioning between CCGs and NHS England teams, and rising pressures due to local authority cuts to social care and residential housing. The taskforce recommended that clearer national expectations of and support for local commissioners, greater flexibility in use of financial levers, and full accountability for commissioners through data on spend and outcomes is critical for improving outcomes.

Improvement in child and adolescent services is particularly reliant on greater transparency in spend: the taskforce recommended that CCGs should 'publish data on levels of mental health spend in their annual report and accounts, by condition and per capita, including for child and adolescent mental health services, from 2017/18 onwards.'

At the moment, commissioners do provide some data about how much they spend on mental health but this is usually limited. This in itself does not indicate whether parity of esteem has been met and in which areas, only how much funding has been allocated and consumed. We asked respondents how confident they were that the additional reporting requirement would promote the principle of parity of esteem – only 18% of providers and 61% of commissioners were confident that this would support commissioners to meet their parity of esteem commitments (figure 3).

**Figure 3:**  
**Confidence in whether publishing expenditure on mental health spend will support commissioners meet their parity of esteem commitments**



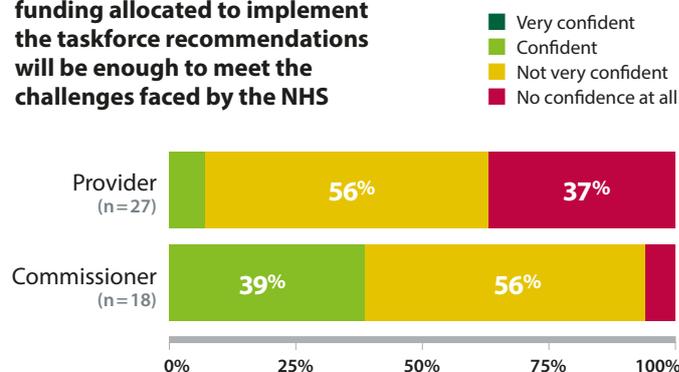
The diverging views between local organisations clearly indicate that although transparency could have a useful role to play in holding organisations to account for the funding spent on mental health services, this in itself will not be sufficient.

Some respondents were also concerned that this requirement would still prevent different levels of investment at the organisational level from being highlighted, one of the key issues identified in this report. One commissioner also expressed concern that this would simply create another league table between organisations, without supporting organisations to manage their conflicting priorities.

## THE SECTOR IS OVERWHELMINGLY NOT CONFIDENT THAT THE £1 BILLION TO IMPLEMENT THE MENTAL HEALTH TASKFORCE RECOMMENDATIONS IS ENOUGH TO MEET RISING DEMAND AND COSTS FOR SERVICES

The results from our survey paint a picture that the sector is concerned that the funding allocated to implement the taskforce recommendations will not be enough – over 90% of providers and 60% of commissioners were not confident that the £1 billion is sufficient to meet the challenges faced by NHS mental health services (figure 4).

**Figure 4:**  
**Confidence in whether the funding allocated to implement the taskforce recommendations will be enough to meet the challenges faced by the NHS**



One commissioner indicated that they were not confident because ‘it does not take into account the typical remuneration model in mental health, and the need to ensure underlying sustainability...the funds provide no support to underpin historic funding issues as they are linked to new must do targets’.

Commissioners also cited concerns with the fact that the investment is likely to be subsumed within their allocations, making it difficult to clearly identify the amount available for specific service priorities. One finance lead said: ‘It is not real additional funding... given the financial position of many CCGs the funding will be required to support existing services’.



## RECOMMENDATIONS FOR ACTION: WHAT NEEDS TO HAPPEN NEXT?

The additional funding for mental health services, and the ongoing commitment in the planning guidance for commissioners to increase their real terms investment, represent a real opportunity to reset the way mental health services are prioritised. As things stand, our survey highlights that this opportunity has not yet been realised across local health economies in 2015/16 and there are concerns for 2016/17.

We all recognise that substantial changes are required to improve access to mental health services but unless funding reaches frontline providers, we are not yet moving towards parity of esteem for these services. This is because demand for mental health services is rising across the whole spectrum of care, and commissioners have very difficult pressures to balance competing and conflicting priorities for funding. Without a sustained real terms uplift in investment for mental health, people who desperately require these services – especially secondary and specialised care – will continue to increasingly lose out relative to patients requiring physical healthcare.

Many local areas benefit from positive collaboration and working relationships between commissioners and providers – these areas tend to enable a positive environment in which discussions about investment in mental health services can be supported. However, there are still too many areas where commissioners have not been given a framework or resources to invest in mental health services, and the end result is that NHS providers do not have the resources to improve services for patients and service users.

NHS Providers and the HFMA believe that four things need to happen if we are to better support NHS organisations to meet their parity of esteem commitments over the course of this parliament.

1 Clarity from the government and system leaders about how much is being made available for mental health services, and in which areas. We know that there is £1 billion to implement the recommendations from the mental health taskforce, but it is not clear whether this separate or in addition to the £600 million previously announced in the 2015/16 autumn statement and the £1.25 billion for children and young people's services. It is also unclear whether this is incorporated in to commissioner allocations or will be funded through sustainability and transformation funding. Given the scale and scope of the recommendations within the taskforce, we also ask the Department of Health and NHS England to indicate which of the taskforce's recommendations can be delivered in this parliament within the funding available, and to agree a comprehensive costed implementation plan by August 2016.

2 Explicit alignment is needed about what it means to meet parity of esteem commitments. At both national and local level, organisations are interpreting the requirements in different ways, leading to a patchwork of investment and services for patients. This also creates distrust between local organisations and frustrates commissioners and providers in their attempts to work more closely together. NHS Improvement and NHS England need to support providers and commissioners respectively to agree an understanding of what parity of esteem means in practice at local level, and key questions need to be clarified such as:

- How can commissioners demonstrate that they are increasing their real terms investment without placing an undue burden on them?
- What is the methodology which should be used for determining the parity of esteem uplift for services?

- Is parity of esteem something that should relate to all mental health spend across primary, secondary and specialised care, or should it be guaranteed at an individual service and/or provider level?
- Should certain services be explicitly included/excluded in the definition of mental health for parity of esteem purposes?
- What baseline should commissioners use to demonstrate that they are increasing their investment, and should any cost pressures (national or local) be taken in to account?

3 Better enforcement and support for local organisations. Our survey highlights a great deal of local variation about how the rules are being interpreted and responded to. NHS England needs to work with local organisations to ensure that the rules are consistently and fairly implemented. Where organisations are struggling to invest in line with the guidance, support should be required to ensure that challenges are addressed.

4 Greater transparency across the system about how much is being spent on mental health services. The recommendation in the taskforce for commissioners to publish in detail spend on services is helpful, but NHS England will need to support organisations to implement this in a meaningful and simple way. We also need to recognise that this in itself is not enough to achieve parity, and we need to avoid this simply being a measure to create a league table of commissioners.

**The Healthcare Financial Management Association (HFMA)** is the professional body for finance staff in healthcare. For more than 60 years it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has a particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.



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**NHS Providers** is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high quality, patient focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 94% of all NHS foundation trusts and aspirant trusts in membership, collectively accounting for £65 billion of annual expenditure and employing more than 928,000 staff.



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