Royal College of Nursing

Frontline First
Turning back the clock? RCN report on mental health services in the UK

Contents

Forewords

Mental illness touches the lives of all of us, with an estimated one in four people in the UK experiencing a mental health problem every year. The experience can be frightening, both for those directly affected and for their friends and families. It takes a special kind of nurse, with the right mix of skills and experience, to provide the highly specialised care they need.

There is a growing recognition that the disparity between physical and mental health care cannot be allowed to continue, and governments across the UK have made important commitments to redressing the balance. Yet mental health nursing is under acute pressure, with cuts leading to the loss of more than 3,300 posts over the past four years. This has impacted on the thousands of people who are receiving treatment in both hospitals and in community services, leading to an increase in people experiencing crises and breakdowns as well as unnecessary hospital admissions and delayed discharges. It's a false economy with real, human consequences and is simply unacceptable.

This special report seeks to highlight the issues facing the mental health nursing community and we're delighted to have the support of Rethink Mental Illness in putting the case forward for greater investment in this vital service.

The report makes for sobering reading but with the right resources and funding, and commitment from all levels of Government, we can ensure that this important arm of nursing is protected so that it can continue to care and support for people when they are at their most vulnerable. To do otherwise would plainly be wrong.

Dr Peter Carter,
RCN Chief Executive & General Secretary

Our mental health system is in crisis, and cuts to nursing are making the situation even graver.

Mental health care has always been chronically underfunded, and spending has been slashed further in recent years. Since 2010 thousands of beds on mental health wards have been closed down, while vital community services like Early Intervention in Psychosis are struggling to survive because of funding cuts.

At the same time, the number of people admitted to mental health services has risen, resulting in a huge gulf between the demand for care and the support that is actually available. The Government in England has promised to put mental health on a par with physical health in the NHS, but that is far from a reality as things stand.

Nowhere is this disparity more evident than in nursing where more than 3,300 posts have been lost from mental health services in the past four years.

It does not take an expert to see why these figures are so worrying. Our nursing workforce is increasingly unable to cope with the demand for support across the country. Community psychiatric nurses have seen their caseloads spiral to unsustainable levels, while nurses working in mental health hospitals are dangerously overstretched.

But this is not just an issue of inadequate staff numbers. Another major problem is the worrying loss of specialist nursing skills and expertise. Senior mental health nurses, who have the expertise to implement the full range of treatments recommended by the National Institute for Health and Care Excellence (NICE), have been disproportionately affected by cuts. Too often, they are being replaced with cheaper, less skilled nurses or care assistants.

As a result, our nursing workforce is increasingly ill-equipped to give people with mental illness the specialist, recovery-driven care they need. Nurses are being forced to take a risk-averse approach to care which prioritises keeping people safe, over helping them get better.

Not only is this detrimental to the quality of care that people receive, it makes little financial sense. Reducing nursing staff levels and skill sets will result in more people needing long-term support, including expensive hospital treatment. The costs to the NHS in the long run will far outweigh any short-term savings it gains.

The Government in England recently announced plans to introduce maximum waiting times for mental health treatment for the first time. It also committed to spending an extra £120m on mental health services over the next two years.

This was a very welcome step towards making mental health equal to physical health. But for that to truly become a reality, nurses must have the resources and expertise necessary to give people with mental illness the care they need.

That responsibility lies with local health decision-makers, who are responsible for commissioning mental health services. They need to urgently address the dire staff shortages in our nursing workforce, and to invest in training and recruiting specialist mental health nurses, with the skills and experience to offer recovery-driven care.

The Government in England must also make this a priority by working together with the NHS to address these problems. We cannot stand aside while our nursing workforce is hollowed out – the human cost is too great.

Mark Winstanley,
Chief Executive, Rethink Mental Illness

2. Executive summary

Since July 2010, the Royal College of Nursing (RCN) *Frontline First* campaign has monitored the impact of efficiency savings on frontline services, repeatedly raising concerns that cuts to services, cuts to the nursing workforce and a failure to plan for the future, have left the NHS understaffed and patient care compromised.

This special *Frontline First* report *Turning back the clock? Mental health services in the UK* shows that mental health services are now under unprecedented strain, experiencing a steep fall in nurse numbers and available beds despite rising demand.

The UK governments have acknowledged the significant social and economic burden caused by not treating mental illness. However, the experiences of people accessing services and of the nurses working in mental health settings suggests that there is a significant gap between some of the policy commitments and the provision of, and access to, services. This gulf between rhetoric and reality threatens to leave vulnerable patients without vital support.

The examples outlined in this report highlight the significant variation in the services for people with mental illness.

Since 2010 all countries in the UK have seen a significant reduction in the number of available beds in mental health services. Whilst it could be argued that the reduction in beds is as a direct result of shifting services to the community, there is strong evidence that in some areas there are simply not enough beds to meet the acute inpatient demand.

When mental health services are available and working well they keep people in community services out of hospital. However, when local services are reconfigured or services are lost, many people are not able to access the assertive outreach or early intervention services they need, resulting in them presenting with more complex needs later on, often requiring inpatient care.

This report also suggests that due to the loss of prevention and early intervention services, many people experiencing mental illness are unable to access inpatient treatment in their local area unless they have been sectioned under mental health legislation.

Despite pledges to improve mental health care and a new focus on community services, the last four years have seen a drop of more than 3,300 mental health posts across the UK in both hospital and community settings. This report shows that more experienced nurses have been disproportionately lost and highlights the serious implications that the loss of these skills has for both patients and nurses alike.

Finally, this report takes a closer look at each of the countries in the UK, outlining specific policy commitments and the current challenges facing mental health services in the different health and social care landscapes.

Recommendations

The RCN proposes the following recommendations to address the issues highlighted in the report.

1) **Governments must ensure there is equal access to mental health services and that the right treatment is available for people when they need it.**
2) **Governments and NHS providers must ensure that the commitment to parity of esteem is directly reflected in the funding, commissioning of services, workforce planning, and patient outcomes.**
3) **Local commissioners and health boards must make available enough local beds to meet demand.**
4) **The principle of least restriction must be embedded across all mental health services. Detention under mental health legislation should always be based on clinical opinion and never be a result of local failures to provide appropriate care. Due to the significant increase in detentions under the Mental Health Act there should be a national objective set to reduce detention rates in England.**
5) **There must be a consistent shift across the UK from inpatient acute care to community-based services which recognises that prevention and early intervention results in better outcomes, reduces the pressure on acute services, and reduces the overall cost to the NHS in the long term.**
6) **Urgent action must be taken to address the workforce shortages. Resources must be committed to training and recruiting enough mental health nurses who are able to deliver specialist care in the changing health and social care landscape.**
7) **NHS providers must invest in the current mental health nursing workforce. Band 6, 7 and 8 mental health nurses should be developed to become advance practitioners to deliver effective recovery-led care in mental health services.**
8) **There must be a sustainable and long-term workforce planning strategy which acknowledges the current challenges facing the mental health nursing workforce.**

Mental illness in the UK

Over the past few months there has been extensive commentary focusing on how increases in demand and cuts to funding are impacting on the effective delivery of mental health services. The Royal College of Psychiatrists, the BMA, the Nuffield Trust, the *Health Service Journal* and the Chief Medical Officer for England have all published comprehensive reports on mental health services, giving a clearer picture of the impact of mental illness on individuals in the UK. For example:

- one in every four people will experience a mental health problem in the course of a year
- on average people with a mental illness die 15 to 20 years earlier than people without a mental illness
- there is a large treatment gap, with 75 per cent of people with a mental illness receiving no treatment at all
- suicide remains the most common cause of death in men under the age of 35
- the UK has one of the highest rates of self harm in Europe.

(CMO, 2014 and MHF, 2014)

Mental health policy in the UK

The individual governments in the UK have acknowledged the significant social and economic burden caused by not treating mental illness. The government in Scotland published its *Mental health strategy 2012-2015* which aims to bring together, for the first time, mental health improvement work, mental health prevention and work to improve mental health services, as part of a wider effort to ensure that mental health is given parity with other health conditions. This includes a commitment to delivering faster access to mental health services such as psychological therapies.

In England the Government's report *The Mandate, A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015* also pledged to extend and ensure more open access to the Improving Access to Psychological Therapies (IAPT) programme, announcing parity of esteem as a priority. Parity of esteem refers to valuing mental and physical illness equally. More recently, to assist in the move towards parity, the government in England have announced that from April 2015 they are going to introduce waiting time targets for people requiring talking therapies or treatment for initial episodes of psychosis.

The government in Wales has published *Together for mental health - a strategy for mental health and wellbeing in Wales*, a 10-year strategy for improving the lives of people using mental health services. Progress on this is overseen by a national partnership board. The National Assembly for Wales also passed legislation called The Mental Health (Wales) Measure which places legal duties on health boards and local authorities to improve support for people with mental ill-health.

In Northern Ireland, mental health policy is developed and delivered within the framework of the Bamford review of mental health and learning disability. The Bamford review seeks to focus primarily on the interests of service users and promote a shift in the focus of care delivery away from traditional institutional settings towards a greater emphasis upon providing community-based treatment and care. More recently, the Department of Health, Social Services and Public Safety has published a draft mental capacity bill which, when enacted, will mean that Northern Ireland is the only jurisdiction in the world to combine mental health and mental capacity legislation.

However, the experiences of people accessing services and nurses working in mental health settings would suggest that there is a gap between some of the commitments made within the mental

health policy frameworks of the four countries in the UK and the provision and access to services.

In this report we look at the current pressures on mental health services and changes to the nursing workforce since 2010. By using official statistics and case studies this report highlights the frustrations and difficulties experienced by people attempting to access services and nurses on the frontline.

The strain on mental health services

The provision of care continues to change across the UK. Mental health services, among others, are being re-provided in primary and community care settings, by both NHS and independent providers. This is aimed at delivering care closer to home and giving better access to an increasingly integrated health and social care system.

All countries in the UK support a policy of providing mental health in the community, yet the experience of people and nurses suggests there is significant variation in the delivery and access to mental health services within individual countries and across the UK.

The Maternal Mental Health Alliance (MMHA) has mapped the provision of mental health services for pregnant and postnatal women suffering from a mental illness (http://everyonesbusiness.org.uk). This exercise highlighted the significant disparity across the UK. The MMHA also recently commissioned a report which estimated the cost of cost of perinatal mental health problems at £8.1bn a year (LSE and Centre for Mental Health, 2014).

The findings of the House of Commons Health Committee recent report *Children's and adolescents' mental health and CAMHS* show the ingrained problems running through CAMHS services, from prevention, early intervention to inpatient services. The committee saw evidence of increased referral thresholds, growing waiting times, a rise in demand for CAMHS services, and serious problems facing those in transition from CAMHS to adult services. The committee concluded that there is unacceptable variation in the standards of access and quality of CAMHS services for children and young people, especially those from vulnerable groups (HoC Health Committee, 2014).

Similarly, Rethink Mental Illness in England recently published a report, *Lost generation*, highlighting that services providing early intervention in psychosis for young people aged 14 to 35 are getting worse, not better. The report shows that 50 per cent of early intervention in psychosis services had their budget cut in the past year, some by as much as 20 per cent. Fifty eight per cent of these services have lost staff in the past year and 53 per cent say the quality of their service has decreased over the past year (Rethink Mental Illness, 2014).

These examples highlight the significant variation in services being provided and demonstrate that essential early intervention services in the community are just as vulnerable to funding and workforce cuts as acute settings.

The next section of this report looks more closely at the pressures on acute services. By exploring indicators such as available beds, inpatient admissions and detentions, we highlight some key pressure points.

Available beds

When a person goes into crisis, sometimes there is a need for them to be admitted to hospital. This may be in an acute mental health unit or a mental health hospital. There are also occasions whereby people are assessed as being a risk to themselves or others and need to be detained under the relevant mental health legislation. Therefore, it is important that mental health services have sufficient numbers of beds ready and available for those who need them.

Since 2010 all countries in the UK have seen a significant reduction in the number of available beds in mental health services. Table 1 shows that Northern Ireland has

seen the greatest reduction, having lost 35 per cent of available beds since 2009-10. Scotland has lost 17 per cent, Wales 12 per cent and England six per cent of available beds. Whilst England has the smallest reduction this does equate to an overall loss of 1,500 mental health beds across the country.

When mental health services are cut, it is often claimed that quality, cost-effective services will be re-provided in the community. However, the RCN believes that the re-provision of these services in the community is not happening consistently. Furthermore, trusts have been closing beds and redeploying resources as a way to help meet efficiency savings targets.

Whilst it could be argued that the reduction in beds is as a direct result of shifting services to the community, there is strong evidence that in some areas there are simply not enough beds to meet the acute inpatient demand. The *Health Service Journal* recently reported that a lack of available beds has resulted in some people in England being sent hundreds of miles away from their home to ensure that they can be admitted and allocated a bed (Lintern, 2014).

Being admitted to a hospital located miles away from home and friends and family during a crisis has a significant detrimental impact on a person's health. Too often nurses are seeing the long term impact on a person's recovery. The RCN believes that when people are in crisis and need to be admitted to acute services, **local commissioners and health boards must make available enough local beds to meet demand**.

Eve's story

In January 2010, I gave birth to my son in London. Very quickly, I became really unwell and a week after having him, I was diagnosed with postnatal depression and given anti-depressants. However, it became very apparent to my family that I was suffering with something more serious as I was experiencing suicidal thoughts, hallucinations and extreme anxiety. For six weeks I visited my GP but was continuously told there was no help other than anti-depressants.

My husband had spoken to a mental health charity who told him about perinatal psychiatrists and mother and baby units. The GP did not know anything about these and told me that there were no services available in the area.

My husband found out there was a mother and baby unit in Nottingham where his parents lived. After six weeks I felt that I wanted to die and had symptoms of psychosis. My husband took me to hospital in Nottingham and within an hour, I was admitted to the mother and baby unit and put on anti-psychotics. If we hadn't moved to Nottingham and got into the unit, I wouldn't be alive today. I was extremely lucky as we had the finances and means to move to the other end of the country to access support but this should never ever have had to happen.

Throughout my recovery I was supported by my community psychiatric nurse who visited frequently. After four months I was discharged from the unit in Nottingham and was well enough to return to London. My GP told me there was no way I could access cognitive behavioural therapy treatment. I was told that services in London did not know how to support someone with a perinatal mental illness.

Due to my situation the unit in Nottingham then offered to keep me as an outpatient for a year and provide me with weekly cognitive behavioural therapy treatment. I had to spend £200 a week travelling to Nottingham. The travelling was extremely difficult for me as I was still suffering from anxiety and learning how to be on my own with my child. I am now part of the Maternal Mental Health Alliance and wanted to share my story to raise awareness of perinatal mental illness.

Table 1: Average number of available staffed mental health beds 2009-2014

Available beds	2009-10	2010-11	2011-12	2012-13	2013-14	Number of beds lost	% change 2009 to 2013-14
Northern Ireland	995	821	757	695	646	-349	-35%
Scotland	5,263	4,906	4,594	4,554	4,380	-883	-17%
Wales	2,016	1,919	1,855	1,766	-	-251	-12%
England	-	23,448	23,150	22,396	21,949	-1,499	-6%

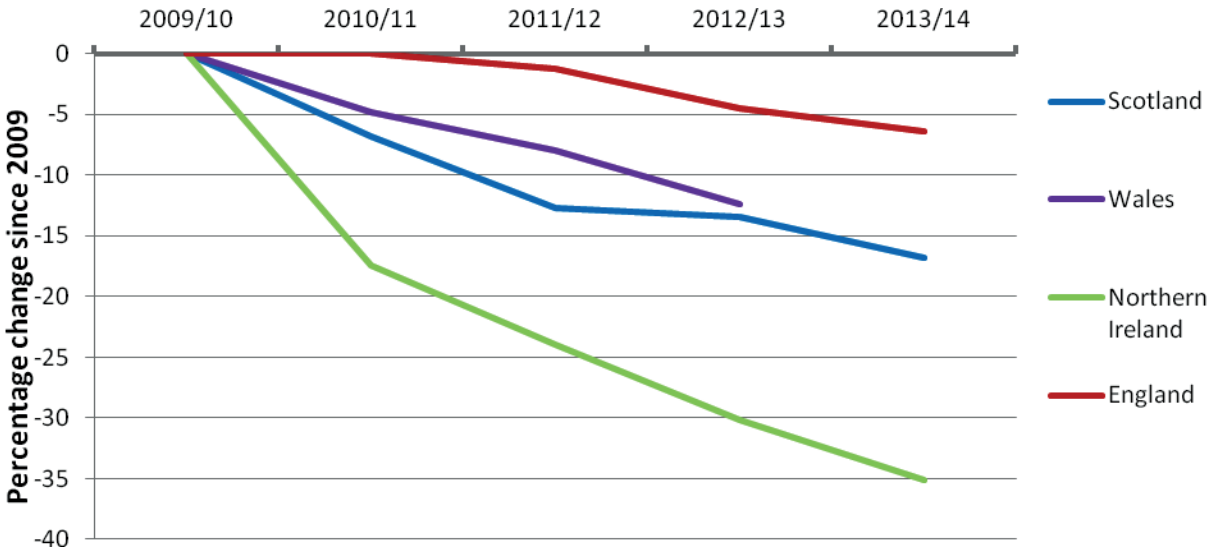
Note: **Northern Ireland data based on average available beds which are open overnight under the Mental Health POC, this includes all mental health specialities, DHSSPSNI (2014).**

Scotland data based on staffed beds available for reception of patient for categories listed under psychiatry which include adolescent psychiatry, child psychiatry, forensic psychiatry, general psychiatry (mental illness) and psychiatry of old age, ISD Scotland (2014a).

Wales data based on average daily available staffed beds for mental illness, forensic psychiatry, old age psychiatry, and child and adolescent psychiatry StatsWales (2013b).

England yearly data is the average of quarterly figures that refer to the number of available beds open overnight that are under the care of consultants in the mental illness specialities, NHS England (2014).

Figure 1: Percentage of available mental health beds lost since 2009



Inpatient admissions

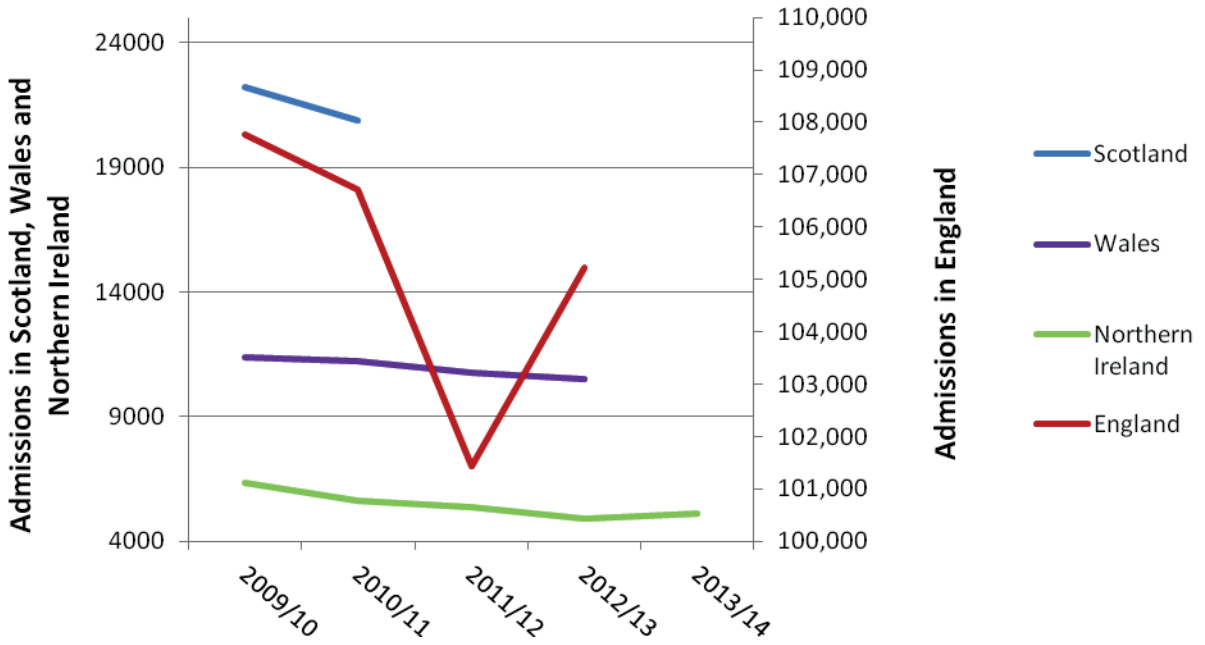
Figure 2 shows the inpatient admissions levels across the UK.

Since 2009-10 inpatient admissions have reduced in Northern Ireland, Scotland and Wales, by 19 per cent, six per cent and seven per cent respectively. There has been a gradual decline in the number of admissions across these countries. However, England has seen varying levels of admissions over the same period, with a significant increase of four per cent from 2011-12.

Worryingly, mental health services in England have experienced both a reduction in beds, and an additional 3,800 admissions from 2011-12 to 2012-13. We know the number of people diagnosed with mental illness has been increasing, therefore, the decreases seen in the other UK nations suggest that patients are accessing and receiving treatment earlier which in turn is helping prevent the need for inpatient care.

In England, the varying rates of admissions, which include detentions under mental health legislation, can be attributed to the reconfiguration of services and the

Figure 2: Number of admissions to mental health services 2009-2014



Note: **Scotland data for 2011/12 is not available as the figure excludes one NHS board, ISD Scotland (2012). Data for 2012/13 and 2013/14 are not available due to data quality issues.**
Wales data refers to all admissions formal or informal, to mental health facilities, Statistics for Wales (2013a).
Northern Ireland data refers to total admissions under the Mental Health POC, DHSSPSNI (2014).
England data refers to all inpatient admissions in all NHS funded care, including the independent sector, HSCIC (2013).

retraction of assertive outreach and early intervention services. When these services are available and working well they keep people in community services out of hospital. However, when local services are reconfigured or services are lost, many people are not able to access early intervention services resulting in them presenting with more complex needs later, requiring inpatient care.

In November 2013, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness published a report which demonstrated the association between changes to mental health services, especially to community care, and a reduction in suicide rates. The study found that the service change which resulted in the biggest fall in suicide rates in the UK is the implementation of crisis resolution/ home treatment or assertive outreach teams (NCISH, 2013). Again, this reinforces the need for early intervention services to be in place in the community.

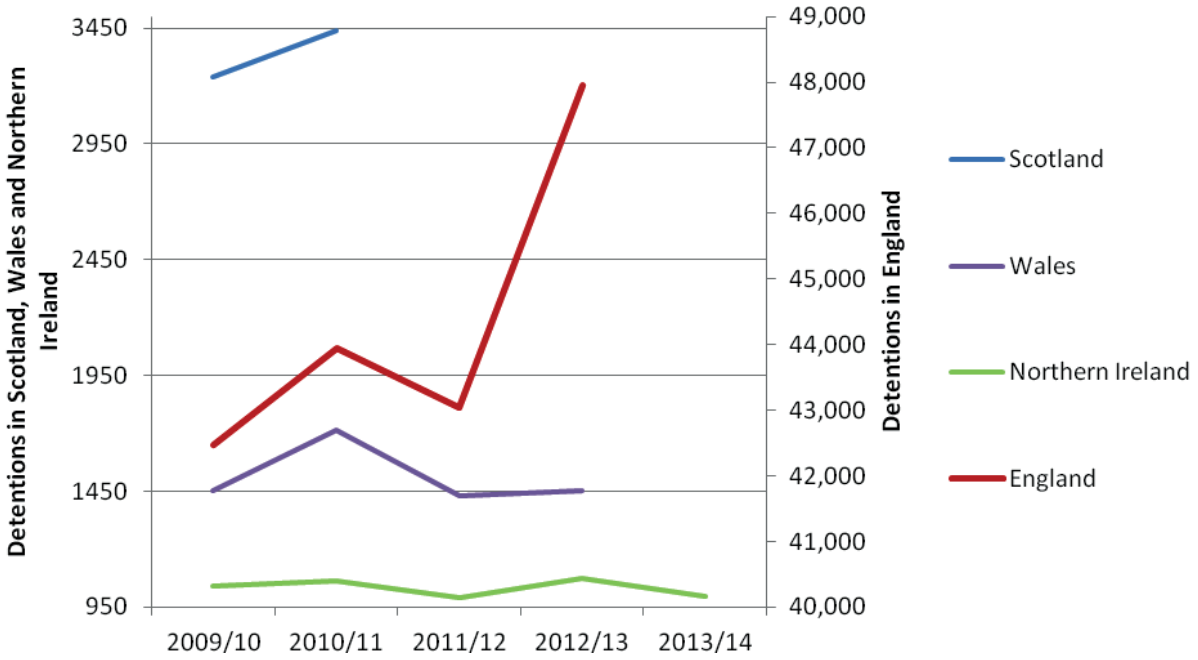
Formal legal detentions

When people are admitted to inpatient mental health services, this is done either with their consent or formally under detention legislation. Countries across the UK have different legislative mechanisms under which people are detained. Figure 3 shows the number of people in the UK who have been detained in the past five years.

The number of detentions in Wales and Northern Ireland has remained relatively stable over the past five years with both seeing reductions in the number of detentions over that period. To a certain extent, this suggests that earlier mental health interventions are proving successful in stabilising and reducing the number of admissions, including detentions over the past five years. In Scotland, some aspects of legal detention are currently being reviewed under proposed changes to the Mental Health (Care and Treatment) (Scotland) Act 2003.

However, in England the number of people being detained under the Mental Health Act 1983 has increased by 13 per cent, from 42,479 detentions in 2009-10 to 47,961 detentions in 2012-13.

Figure 3: Number of detentions under the relevant mental health legislation 2009-2014



Note: **Scotland data refers to a formal admission to psychiatric inpatient facilities under the jurisdiction of the Mental Health (Scotland) acts 1960 and 1984 and the Mental Health (Care and Treatment) (Scotland) Act 2003 Data for 2011/12 is not available as the figure excludes one NHS board, ISD Scotland (2012). Data for 2012/13 and 2013/14 are not available due to data quality issues.**
Wales data refers to formal admissions under the Mental Health Act 1983, Statistics for Wales (2013).
Northern Ireland data refers to the compulsory admissions within the Mental Health POC under the Mental Health (NI) Order 1986, DHSSPSNI (2014).
England data refers to number of people detained under the Mental Health Act 1983 in all NHS funded settings including independent providers, HSCIC (2013).

The Care Quality Commission (CQC) oversees the implementation of the Mental Health Act 1983 in England. In its recent report, *Monitoring the Mental Health Act in 2012/13*, it acknowledges that 2012-13 saw the highest number of uses of the legislation ever recorded.

The CQC report also shows that certain black and minority ethnic (BME) groups are over represented in both inpatient mental health services and in terms of detentions. Detentions of some BME groups are six and four times higher than expected. Detentions relating to the criminal justice system were also higher for some BME groups, showing pathways into mental health services are different for these groups. The CQC explains that these adverse pathways could be a result of inequalities to access, poorer outcomes from mental health services or a reflection in the different service provisions across England (CQC, 2014). The over representation of certain BME groups in mental health services and the poorer outcomes they receive must be a key consideration for those planning and delivering services.

The report also cites that during the post-legislative scrutiny of the act it was suggested that the threshold criteria to access a bed in hospital was set too high, and that this has resulted in some clinicians resorting to the use of sectioning powers to secure hospital access for people who would have otherwise been admitted as informal patients.

The CQC also reports that they have seen cases where people have been detained, not because they objected to being admitted to hospital but because they objected to admission to an available bed some distance from their home. The CQC acknowledges that research indicates a relationship between lack of bed capacity and increases in detention (CQC, 2014).

In October 2014, the CQC also published a map showing the locations of designated health-based places of safety for people being detained under Section 136 of the act. In response Mark Winstanley, CEO of Rethink

Mental Illness said 'In many parts of the country, there are no health-based places of safety full-stop. As a result thousands of people in great mental distress, including children, are ending up in police cells because there is no other support available.'

Formally detaining people under mental health legislation has serious implications for their legal rights (Department of Health 2014). The RCN believes **the principle of least restriction must be embedded across all mental health services. Detention under mental health legislation should always be based on clinical opinion and never be a result of local failures to provide appropriate care. Due to the significant increase in detentions under the Mental Health Act there should be a national objective set to reduce detention rates in England**.

To enable clinicians to apply the principle of least restriction fairly in all cases the NHS must ensure that there are enough health-based places of safety available for children, young people and adults.

In England, the substantial rise in detentions is a strong indicator that the right services are not in place in the community. Vital services are not in place, or where they are, they are so overstretched that people are not receiving the early intervention treatment they need. In practice, people are receiving treatment much later and are far more ill when they finally access mental health services. To help reduce admissions and detentions in England and to continue the trend in Wales and Northern Ireland, there needs to be an adequate range of mental health services commissioned in the community across all regions and nations.

The RCN calls for the NHS to deliver **a consistent shift across the UK from inpatient acute care to community-based services which recognises that prevention and early intervention results in better outcomes, reduces the pressure on acute services, and reduces the overall cost to the NHS in the long term**.

Kerry's story

Throughout my childhood I had emotional and behavioural difficulties. But it wasn't until I was nineteen and in my first year of university when I first started experiencing delusions and hearing voices. The first psychiatrist I saw was really unhelpful. She basically said that I should lower my expectations and give up my degree. I didn't get the right treatment, and I felt like I was in 'pass the parcel'.

My GP would refer me, but then I'd be told I wasn't getting treatment because I didn't fit the right boxes. Yet no-one else would see me because I was deemed 'too ill' or 'psychotic'. For years I was bounced around with endless horrible assessments and no help.

Then in my early 20s, I was sexually assaulted by someone I considered to be my friend. I decided not to report it at the time, but it made me feel very depressed, anxious and paranoid. After I saw the man again at a festival I spoke to a counsellor who was there, but she was more interested in the fact that I heard voices and I ended up being removed from the site by the police. I spent fourteen hours in a police cell, and was only released after I was assessed by a Mental Health Act team - a psychiatrist, two social workers and a GP.

After that I decided to report the original sexual assault to the police, but I didn't feel like they took me seriously. That all took a serious toll on my mental health. I became very unwell and ended up being sectioned for four months out of my local area.

I've experienced inadequate treatment many different times. Once I had a bad psychotic episode, and thought I had to set myself on fire to save the world. I went to A&E because I was scared that I couldn't keep myself safe. They said they had no capacity to help me, but that they would send the crisis team in the morning. But I was in crisis there and then, and the morning was far too late – I was lucky that I didn't manage to hurt myself badly that night. I was also told on another occasion in A&E that several doctors and a social worker agreed that I needed to

be sectioned and sent to hospital, but then they changed their minds and sent me home because there were no hospital beds.

In the end, I waited for seven years before I finally got access to the early intervention psychosis (EIP) team, but I cannot say enough good things about the support I got from it – the staff have been amazing. With their support, I have gone from being sectioned to finishing my Masters in public health.

Now I'm engaged to be married and have a job as a researcher on antibiotic resistance for the NHS. I believe the key to my recovery has been my EIP team, as well as peer support groups and my psychologist. I also rely on the support of my partner and friends, and have found running, dancing and mental health campaigning really beneficial for my mental health.

The mental health nursing workforce

Workforce numbers

Mental health nurses are specifically trained to work in mental health care settings and to treat and care for people with a wide range of illnesses and complex needs, from dementia to schizophrenia, to personality disorder. Mental health is widely recognised as a specialist and skilled area of nursing.

Since 2012 there has been a push to increase the overall nursing workforce in the UK, which had fallen sharply after 2010.

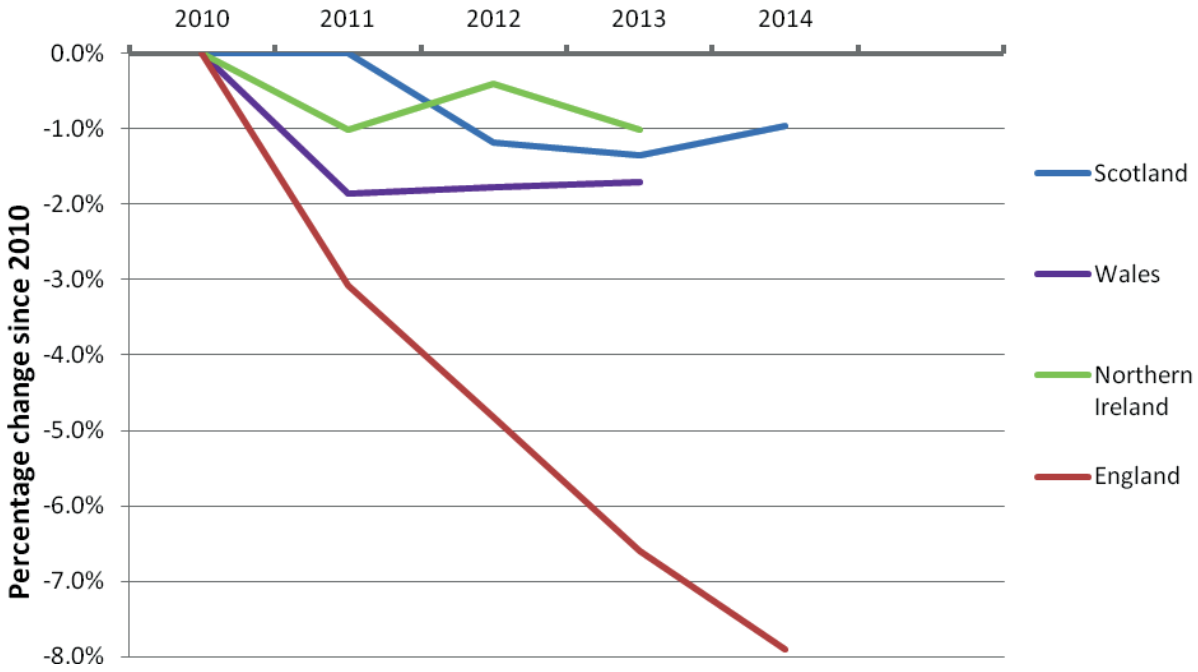
Table 2 shows that by 2013 Northern Ireland had recruited an extra 180 qualified nurses and Wales increased nursing numbers by 97 but had lost 16 and 39 mental health nurses respectively. From 2011 to 2014 the NHS in Scotland had recruited an extra 1,183 nurses overall but lost 64 mental health nurses. By July 2014 the NHS in England had recruited an extra 3,734 qualified nurses since 2010, but lost 3,265 mental health nurses, a reduction of eight per cent of the mental health nursing workforce as seen in figure 4.

Table 2: WTE qualified nursing, midwifery and health visiting staff in mental health services and all settings, England, Wales, Scotland and Northern Ireland 2010-2014

		2010	2011	2012	2013	2014	Change 2010 to 2013-14	% Change 2010 to 2013-14
England	Mental health	41,320	40,052	39,325	38,590	38,055	-3,265	-8%
	All settings	309,139	306,346	305,060	307,692	312,873	3,734	1%
Scotland	Mental health	-	6,668	6,589	6,578	6604	-64	-1%
	All settings	-	41,495	41,159	41,869	42,678	1,183	3%
Wales	Mental health	3,043	2,998	3,015	3,004	-	-39	-1%
	All settings	21,783	21,686	21,755	21,923	-	97	1%
Northern Ireland	Mental health	1,633	1,581	1,627	1,617	-	-16	-1%
	All settings	17,898	17,516	17,671	18,078	-	180	1%

Note: Percentage change relates to the range of years the data is available.
Data based on nursing, midwifery and health visiting staff on AfC bands 5-9 only.
Data for 2010-2013 based on September figures in that year and for 2014 Scotland figures refer to June and 2014 England numbers refer to July.
All services is the total nursing, midwifery and health visiting staff workforce across all settings, such as acute and elderly, community, learning disabilities, paediatrics and neo-natal.
Data in England includes community psychiatry and other psychiatry nursing, HSCIC (2014) and (2014a).
Data in Scotland refers to mental health nursing, ISD Scotland (2014c).
Data in Wales refers to community psychiatry and other psychiatry nursing and excludes bands 1-4 which are contained in headline figures, StatsWales (2013b).
Data in Northern Ireland DHSSPSNI (2010), (2011), (2012), (2013).

Figure 4: WTE qualified nursing, midwifery and health visiting staff in mental health services, England, Wales, Scotland and Northern Ireland since 2010



One possible explanation for the decline in nursing numbers in England is that with the re-provision of mental health services to independent providers some nurses have moved over to the new providers and will no longer be recorded in NHS numbers. However, there is currently no way of monitoring the number of nurses and skill mix in services delivered by independent providers.

The RCN believes that there should be greater transparency in the workforce and patient safety information that is publicly available for all NHS-funded services. Furthermore, as highlighted earlier in this report, it appears that the re-provision of mental health services to independent providers has not resulted in reduced demand on NHS organisations. The loss of 3,265 nurses in five years is therefore deeply worrying.

Mental health nurses are central to successfully making the transition from providing services in acute settings to the community. The decline in the number of nurses will impact on the effective implementation of this policy.

The RCN believes that **urgent action must be taken to address the workforce shortages.**

Resources must be committed to training and recruiting enough mental health nurses who are able to deliver specialist care in the changing health and social care landscape.

A mental health nurse's story

A nurse who has worked in mental health for more than 25 years reflected on the gap between stated policy and the reality on the ground.

"There is no evidence in my trust for the development of nurse-led services in the last 12 months. There are no moves to achieve this concept of parity.

Access on paper is marvellous including self referral but in reality the number of referrals mean that they do not receive a quality service. One team has had up to 11 locum practitioners recently. The real question is accessing what - another unsatisfactory assessment?

Services like liaison psychiatry have been merged with crisis teams and essentially the service has vanished. The teams run short staffed all the time and frequently there are no practitioners on duty, particularly at night. This means patients have to be transported for over an hour so that they can be assessed.

There are no distinct early intervention or assertive outreach teams now - teams are organised into psychosis and non-psychosis. Staff working in non-psychosis teams are overwhelmed with people labelled personality disordered.

There is probably very little in the last 12 months in terms of support workers doing what is more traditionally RMN work. I did advise some assistant practitioners recently who were key working and writing reports about forensic patients with no support or supervision - this has now stopped.

Mental health has in the last four years suffered massive reversals leaving staff demoralised. I have worked in mental health for more than 25 years and the quality of service in my view is at an all-time low."

Loss of skills in mental health nursing

It is crucial that mental health services are adequately staffed with the right number of nurses. Mental health wards must have safe staffing levels to ensure that nurses can provide the appropriate care needed by each individual. When safe staffing numbers are not in place it means that untoward incidences are more likely to occur. However, wards not only need the right number of nurses, they also need the appropriate skill mix.

Senior nurses play a vital role in the care and treatment of patients. They have the experience to lead recovery orientated approaches to treatment, prescribe medication, have knowledge of the full range of NICE and Scottish Intercollegiate Guidelines Network (SIGN) recommended treatments and are best placed to make complex clinical decisions. They also train, supervise and support more junior nurses and students who are building up their knowledge of the specialism.

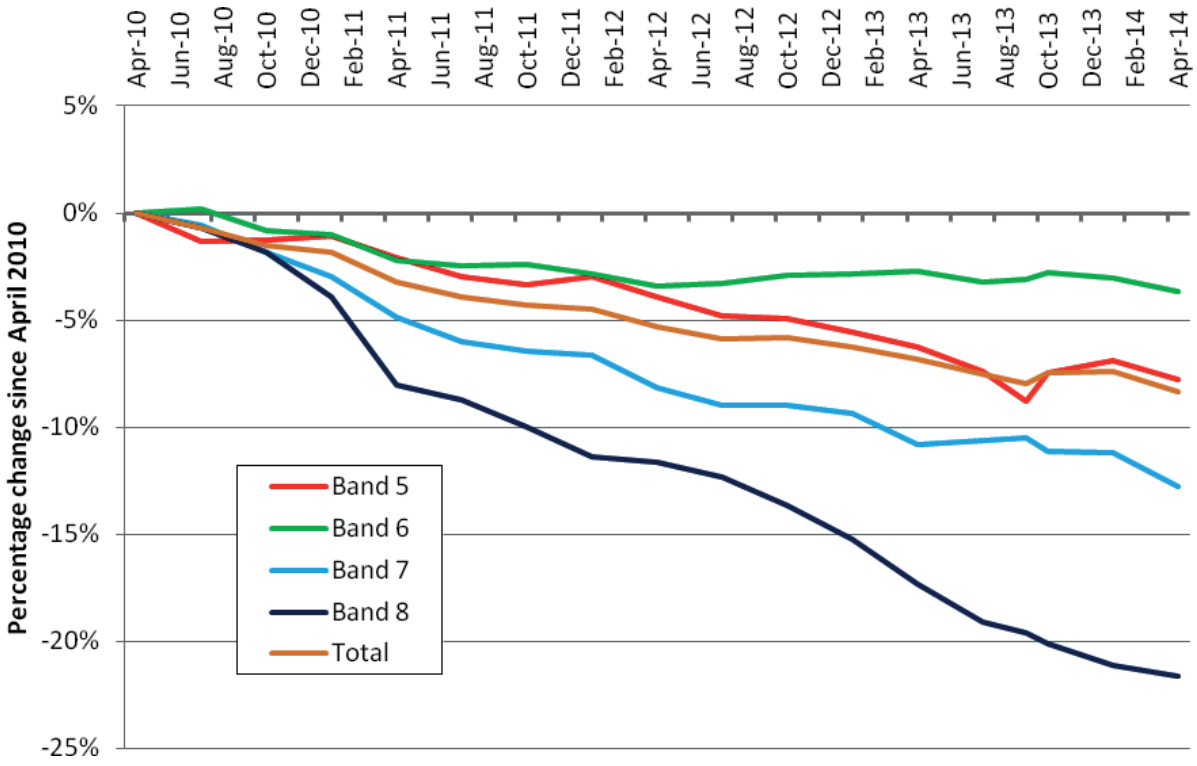
The workforce data demonstrates that the reduction in the overall workforce is compounded by the loss of senior and skilled mental health nurses.

The RCN has obtained figures from the Health and Social Care Information Centre (HSCIC) in England relating to the number of nurses broken down by Agenda for Change band working in mental health since 2010. Figure 5 shows how band 7 and 8 nurses have been disproportionately hit by the cuts. The information we have obtained shows that from April 2010 to April 2014 the NHS in England lost 612 band 6 nurses, 838 band 7 nurses and 488 band 8 nurses.

This would indicate that senior nurses are being downbanded or losing their jobs, and being replaced with nurses on lower bands or health care assistants who cannot offer the same skills as those on higher bands. The RCN believes that in many circumstances, this downbanding is due to the need to reduce the overall pay costs rather than for clinical reasons.

Scotland from September 2011 to June 2014 shows a mixed trend of a 3.1 per cent decrease in the number of band 7 nurses (27.4 whole time equivalent) and a small increase in band 8 staff of 25.1 whole time equivalent posts. Unfortunately there is no comparable data available in Wales and Northern Ireland, but the RCN is aware that similar trends are being seen in these countries.

Figure 5: Percentage change in mental health nurses (community and other psychiatry) by Agenda for Change band, April 2010 - April 2014, England



Source: Information obtained from the Health and Social Care Information Centre, August 2014

The dilution of the skill mix in mental health settings has serious implications for both patients and nurses. Without enough senior nurses there are not sufficient resources in place to deliver therapeutic treatments to support people with recovery, resulting in people not having access to the range of treatments set out in the NICE and SIGN recommendations. An experienced workforce is integral to helping people recover so that they do not need to return to hospital.

In addition, without enough experienced nurses in mental health settings, patients and less experienced staff are being put at risk. Too often vulnerable people are being treated by junior nurses, with nurses in lower bands being put in the position of making important clinical decisions without the necessary support or supervision. We know that when nurses do not get the support they need, there is an impact on patient outcomes, morale and retention of staff.

The RCN has seen evidence of both good and poor practice across mental health settings and shared examples of good practice and learning. Following the closure of a mental health inpatient unit, the RCN in Scotland demonstrated how child and adolescent mental health services in Fife used innovative cost-effective ways of improving outcomes for children and young people by providing a nurse-led intensive therapy service in the community (RCN, 2013).

In England, the Cheshire and Wirral Partnership NHS Foundation Trust demonstrates how nurses can be used dynamically to deliver care previously led by consultant psychiatrists.

The RCN calls on governments to acknowledge the detrimental impact of losing skilled nurses and recommends that the NHS learn from good practice. The RCN believes that **NHS providers must invest in the current mental health nursing workforce. Band 6, 7 and 8 mental health nurses should be developed to become advance practitioners to deliver effective recovery-led care in mental health services**.

An example of good practice

Cheshire and Wirral Partnership NHS Foundation Trust employ advanced nurse practitioners in areas such as memory services, acute inpatients and community mental health services. These practitioners have developed expert knowledge and complex decision making skills within their area of expertise allowing them to undertake a wider scope of practice.

Within the memory services the advanced practitioner in dementia sees the majority of new routine patients for initial assessment; undertaking tests, reviewing results and discussing diagnosis with the patient. If appropriate the advanced practitioner can prescribe psychotropic medications. The advanced practitioner reviews the patient after three months and if all is well, transfers their care to memory review nurses. The memory review nurses are band 6 nurses and undertake activities that were previously done by either the consultant psychiatrist or the advanced practitioner.

The trust has also appointed a nurse consultant within acute care to provide psychological interventions to patients during their hospital admission. The nurse consultant in this role teaches ward staff to deliver psychological interventions ensuring that a therapeutic environment is consistently promoted throughout a patient's admission. The development of all of these roles has enabled the trust to dynamically deal with the reduction in the number of junior doctors as well as allowing consultant psychiatrists to concentrate their efforts on the most complex cases.

Workforce planning

Official data also reveals another concern for the future of the mental health nursing workforce. Across the UK a larger proportion of the mental health nursing workforce is aged over 50 than it was in 2010.

In 2011, 33 per cent of the total mental health nursing workforce in Scotland was over 50, and by 2014 this had risen to 38 per cent. In 2010 in Northern Ireland 26 per cent of the mental health workforce was aged over 50 and in 2013 this had risen to 30 per cent.

Significantly, in England not only are a larger proportion of the workforce aged over 50 than four years ago; the number of mental health nurses over 50 is also significantly higher than in other settings. In 2010, 29 per cent of the mental health nursing workforce was over 50 compared to 26 per cent in all clinical settings. In 2013 the proportion of people aged over 50 grew to 32.3 per cent of the mental health workforce, compared to 28.7 per cent in all settings.

A larger proportion of the mental health nursing workforce being over 50 has implications for the future mental health workforce. This is a concern for mental health services because many of these nurses will have a retirement age of 55. This means that mental health settings may see a drop-off in the number of nurses in the next few years. It is also likely that many of those looking to retire in the next few years will be the most experienced and skilled senior nurses. The RCN is concerned that losing this number of experienced nurses so quickly will put additional stress on an already over-stretched workforce.

The RCN calls for **a sustainable and long-term workforce planning strategy which acknowledges the current challenges facing the mental health nursing workforce**.

A closer look

England

Following the reports of Sir Robert Francis, Sir Bruce Keogh and Professor Don Berwick, there has been a drive in England to expand the nursing workforce. Although the Francis effect (Lintern, 2013) has resulted in more qualified nurses in England overall, this has been primarily focused on acute, elderly and general care settings. The recent increase hides the fact that there are some areas which have suffered a large reduction in nurses.

When looking at data available from May 2010 to July 2014 the reduction in mental health nurses grows to nine per cent, resulting in a loss of 3,790 posts over the four- year period in England. NICE has started work on a safe staffing guideline for mental health inpatient settings which will be issued in 2015 before turning their attention to staffing levels in the community. When safe staffing guidelines are issued, mental health providers must ensure they have enough qualified nurses available to deliver safe care.

The loss of nurses comes at a time of unprecedented demand for mental health services. In 2013, 1,590,332 people in England accessed adult and elderly NHS funded secondary mental health services. This is an increase of 30 per cent from 2008. Although nearly 17,500 people accessed the services of independent providers in 2012-13, including over 4,000 admissions, there were still more people admitted to NHS provided services in 2012-13 than there were in 2011-12 (HSCIC, 2013). This would suggest that the re-commissioning of services to independent providers is not successfully reducing the burden on NHS acute mental health services as was intended.

The increases in the number of people being detained under the Mental Health Act, the rise in inpatient admissions and the loss of available beds demonstrates that mental health services in England are struggling to meet the ever increasing demands placed on them. Pressures on services and a shrinking workforce are occurring against the backdrop of significant pressures on NHS trusts to deliver efficiency savings.

In England, mental health care has historically been underfunded. Currently mental health accounts for only 13 per cent of NHS spending, while being responsible for 28 per cent of all morbidity (CMO, 2014). There is a broad consensus that cuts to funding have heavily impacted on the range of services being provided and the mental health nursing workforce.

Since 2010, both acute and mental health services have had to find efficiency savings. National decisions by Monitor and NHS England have provided additional funds to acute services to assist with the implementation of the Francis recommendations (Monitor and NHS England, 2014). The additional funds allocated to acute services means that proportionally mental health services have had to find greater efficiency savings.

Clinical commissioning groups have a critical role in identifying local needs for mental health services and ensuring providers are delivering care that results in the most effective outcomes for patients. This includes being responsive to the changing needs and shifting demographics of the local population. It also includes considering whether the proposed service meets the needs of everyone in the community. Effective commissioning involves consulting with a range of people who provide and use services. For example, consultation and engagement with people from BME groups is central to effective commissioning for services that are targeting particular communities (Mind, 2013).

Furthermore, commissioners need to ensure close alignment between the commissioning of services and the planning of the local

health workforce, including mental health nursing.

The RCN welcomes the announcement by the Department of Health that an extra £120m will be injected into mental health services next year and that from April 2015 there will be the introduction of new waiting time targets. For people accessing improving access to psychological therapies (IAPT) services the target is that they will be seen in six weeks and no later than 18. For those experiencing their first episode of psychosis the target is two weeks.

The RCN believes these targets are a first step towards achieving parity between physical and mental illnesses.

However, we remain concerned that there will not be the nursing workforce in place to implement the new waiting time targets. To implement the proposed waiting time targets effectively means seeing more people, seeing them more quickly, and ensuring they have access to the full range of NICE recommended treatments. To do this, services need sufficient numbers of readily available mental health nurses with the appropriate skill mix.

In the blueprint for the future of the NHS in England, Chief Executive Simon Stevens, committed to supporting people with dementia and set out his five year ambitions for mental health. The *Five year forward view* also discussed new models of care, including the creation of multispecialty community providers and better integrated care between primary and acute services (NHS England, 2014a).

However, the reconfiguration of mental health services in England over the past few years should provide clinical leaders in the NHS and policy makers with a warning. Many of the ideas in the blueprint around providing services in the community and better integration are not new. Previous policy commitments to re-provide mental health services in the community and using independent providers have not successfully reduced the burden on NHS acute mental health services. The NHS must learn from the real life experiences of people accessing mental health services and nurses on the frontline when introducing new models of care.

The RCN believes that mental health services in England need to be given sufficient workforce and funding to support any further transformations. Despite the 2015 injection of £120m into mental health services there must be a long-term financial plan from the next government to successfully implement the ambitions for mental health services set out in the five year forward plan.

Scotland

The reduction in the mental health nursing workforce is a concern in Scotland, particularly given the profile of the ageing workforce. A reduction in inpatient admissions and inpatient beds within mental health services does not mean that there can simply be a reduction in the numbers of nursing staff to improve outcomes for people with mental illness.

While more patients are now being treated in the community, the patients that do require inpatient services now have more complex needs. This means that there may actually need to be an increase in the number of nurses on mental health wards to cope with the increase in patient acuity.

Though the reduction in mental health inpatient beds and admissions suggests that more people are being treated at home, we have not seen the concerted shift in resources and investment in the community workforce needed to underpin this.

The Scottish referral to treatment access targets for psychological therapies and CAMHS services have helped focus attention on mental health and had a positive impact on promoting parity between mental health services and other health services. However, latest available figures show that there are pressures on meeting these targets by the end of the year (ISD, Scotland 2014b). The general 12-week legal treatment time guarantee introduced in Scotland also applies to mental health services where they

are delivered as planned and elective care on an inpatient or day-case basis. However, since its introduction in 2012 this target has not been met nationally.

There are good examples within Scotland of advanced practice nursing models within mental health services, for example in Ayrshire and Arran and Moray, where nurses are taking on expanded roles to enhance patient care. There needs to be a more co-ordinated national approach, linked to long-term workforce planning and an increase in investment, to support the wide-spread and sustainable adoption of these advanced practice models.

The integration of health and social care in Scotland is a real opportunity to improve how mental health services are delivered. Mental health nursing has a vital role to play in looking at how things can be done differently and in leading change.

Wales

Although the inpatient indicators in Wales would suggest that fewer people are being admitted and detained under the Mental Health Act 1983, we know that mental illness is increasing and there is a continued demand for services.

Mental illness is a contributing factor in the high level of economic inactivity in Wales. The Friedli/Parsonage report estimated that in 2007/08 mental ill-health in Wales cost £7.2bn.

In 2013, 1799 (12 per cent) of adults who responded to the Welsh health survey said that they were being treated for a mental health illness. This figure has been steadily increasing since the survey was first introduced in 2003-04. In areas with high rates of economic inactivity such as the South Wales valleys, there are a large number of people who suffer with anxiety and depression.

There are well-publicised challenges in terms of the quality of care provided in a small number of acute mental health wards in Wales, for example, within the Hergest Unit, Ysbyty Gwynedd in 2013, and more recently the police investigation being undertaken into the standards of care provided to patients admitted to the Ablett Unit, Ysbyty Glan Clwyd. Both service areas are provided by the Betsi Cadwallader University Health Board, North Wales.

The issue of patient vulnerability has been a theme in both units and can also be applied to patients suffering acute mental health problems who are cared for on general ward settings. Additionally, the admission of young people with acute mental health needs into acute adult mental health settings continues to give cause for concern in relation to potential safeguarding and other issues, as well as placement of children and young people requiring tier four intervention out of county and out of country.

In February 2014, The RCN in Wales responded to the Welsh Government's call for consultation related to the provision of mental health services in prisons (RCN, 2014).

People in Wales are facing unacceptable delays in accessing treatment because there are not enough health care professionals employed to provide an appropriate service. The number of young people in Wales waiting more than fourteen weeks for appropriate access to mental health treatment has risen from 199 in January 2013 to 736 in January 2014.

Despite NICE guidelines advising against the routine prescription of anti-depressants, there is evidence to suggest that too many people in Wales are being given long-term repeat anti-depressant prescriptions without access to an alternative treatment. This means that people aren't receiving a follow up appointment with their GP to check that the intervention is working. Reports produced by the All Wales Medicine Strategy Group as part of its clinical effectiveness prescribing programme shows for example that Cwm Taf UHB is leading the UK in highest volumes of anti-depressants per prescribing unit (All Wales Medicine Strategy Group, 2014).

In Wales, there is an urgent need for psychotherapies to be offered in primary care settings as an alternative to anti-depressants. The Mental Health (Wales) Measure 2010 has increased the identification of mental ill-health in primary care but health boards are still struggling to redefine their mental health services into community provision. The financial pressure also means that investment to maintain and improve inpatient services and the physical buildings that provide them is also lacking.

Northern Ireland

In its response to the *Transforming your care* consultation in 2013, the RCN highlighted that not all patients currently receiving long-term institutional care can be relocated within community settings.

The RCN believes that models of care should be designed around the needs of patients, rather than vice versa. RCN members in Northern Ireland have also questioned whether the anticipated cost savings deriving from resettlement will actually be realised, pointing out that supported living on an individual basis can actually be considerably more expensive than providing traditional institutional care, as well as not always being the most appropriate model.

RCN members in Northern Ireland have expressed concern about the speedy implementation of self care, self-directed support and individual budgets in mental health care settings. What started as a well-intentioned attempt to promote independence, choice and dignity may end up as a template for patients and clients being forced into having care that is inappropriate to their needs, instead of tailored individual support.

The RCN is pleased that the Minister in Northern Ireland has listened to the views of nurses and of professional and service user organisations on the draft mental capacity legislation. The RCN believes that a single act covering both mental health and mental capacity will avoid stigmatising patients and will stop placing practitioners in the difficult position of labelling patients according to their mental health status or their mental capacity. The Minister's commitment to ensuring that human rights principles and improved safeguards for patients are incorporated in the legislation is good news for people with a mental illness and those with learning disabilities and all those who provide care for them. It will help to provide the legislative basis for a new service that truly respects the human rights, autonomy and needs of vulnerable patients.

Conclusion

Mental health care has made significant progress over the decades, and with the right support and care those affected can learn to manage their conditions and have a good quality of life. However, this report shows that mental health services in the UK are under unprecedented strain.

There is the very serious risk that if things continue in this vein, mental health provision will decline. The effect of this turning back of the clock for people with mental illness cannot be underestimated.

This report has shown just how serious an impact not having access to the right treatment at the right time can have. It also illustrates how nurses with the right skills and experience can help to enhance services. The variation in the services that are provided across the UK needs to be addressed. The RCN believes that **governments must ensure there is equal access to mental health services and that the right treatment is available for people when they need it**.

The report highlights the gulf between the policy commitments made by governments across the UK and the reality of patients and nurses on the frontline. If governments are serious about treating mental illness in the same way as physical illness, then people must be offered what they need before reaching crisis point.

Although progress has been made in terms of the stated policy commitments, the RCN believes that **governments and NHS providers must ensure that the commitment to parity of esteem is directly reflected in the funding, commissioning of services, workforce planning, and patient outcomes**.

How we tackle mental illness is going to be central to any discussions about the future of the NHS in the UK. The RCN believes that by implementing the recommendations outlined in this report the NHS can move forwards and deliver the core values that have helped to shape modern mental health practice.

References

All Wales Medicine Strategy Group (2014) *Clinical effectiveness prescribing programme (CEPP) Indicators and analysis reports*, Available at: www.awmsg.org/medman_cepp.html?jqprselect=button1 (web) (accessed 17 November 2014)

Care Quality Commission (2014) *Monitoring the Mental Health Act in 2012/13*, London: CQC. Available at: www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf (accessed 11 November 2014)

Care Quality Commission (2014) *Map of health-based places of safety*. Available at: www.cqc.org.uk/public/publications/themed-inspections/thematic-review-mental-health-crisis-care/map-health-based-pl (web) (accessed 11 November 2014)

Centre for Mental Health and LSE (2014) *The cost of perinatal mental health problems*, London: CMH. Available at: www.centreformentalhealth.org.uk/pdfs/Costs_of_perinatal_mh.pdf (accessed 11 November 2014)

Chief Medical Officer Annual Report 2013 (2014) *Public mental health priorities: investing in the evidence*, London: DH. Available at: www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health (accessed 11 November 2014)

Department of Health (2014) *Positive and proactive care: reducing the need for restrictive interventions*, London: DH. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf (accessed 11 November 2014)

Department of Health, Social Services and Public Safety Northern Ireland (2010) *Northern Ireland health and social care workforce census 31*, Belfast: DHSSPSNI. Available at: www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf (accessed 11 November 2014)

Department of Health, Social Services and Public Safety *Northern Ireland (2011) Northern Ireland health and social care workforce census 31*, Belfast: DHSSPSNI. Available at: www.dhsspsni.gov.uk/workforce_census_march_2011.pdf (accessed 11 November 2014)

Department of Health, Social Services and Public Safety Northern Ireland (2012) *Northern Ireland health and social care workforce census 31*, Belfast: DNSSPSNI. Available at: www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf (accessed 11 November 2014)

Department of Health, Social Services and Public Safety Northern Ireland (2013) *Northern Ireland health and social care workforce census 31*, Belfast: DNSSPSNI. Available at: www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf (accessed 11 November 2014)

Department of Health, Social Services and Public Safety Northern Ireland (2014a) *Northern Ireland hospital statistics: mental health and learning disability 2013/14*, Belfast: DNSSPSNI. Available at: www.dhsspsni.gov.uk/mhld-annual-report-13-14.pdf (accessed 11 November 2014)

Department of Health, Social Services and Public Safety Northern Ireland (2014b) *Northern Ireland mental health statistics 2013/14*, Belfast: DNSSPNSI. Available at: www.dhsspsni.gov.uk/mhld-tables-13-14.xls (accessed 11 November 2014)

Health Committee (2014) *Children's and adolescents' mental health and CAMHS*, London: HMSO. Available at: www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf (accessed 11 November 2014)

The Health Foundation and the Nuffield Trust (2014) *Cause for concern: Quality Watch annual statement 2014*, London: THF and NT. Available at: www.nuffieldtrust.org.uk/sites/files/nuffield/publication/qw_annual_statement_web.pdf (accessed 11 November 2014)

Health and Social Care Information Centre (2011) *NHS workforce statistics in England, non-medical staff - 2000-2010*, London: HSCIC. Non-medical detailed results tables available at: www.hscic.gov.uk/catalogue/PUB02070/nhs-staf-non-medi-deta-res-2010-tab2.xls (accessed 11 November 2014)

Health and Social Care Information Centre (2013) *NHS mental health minimum data set*, London: HSCIC. Available at: www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-nat-tab.xlsx (accessed 11 November 2014)

Health and Social Care Information Centre (2014) *NHS workforce statistics in England, non-medical staff - 2003-2013*, London: HSCIC. Non-medical detailed results tables available at: www.hscic.gov.uk/catalogue/PUB13741/nhs-staf-2013-non-med-detl-tab.xlsx (accessed 11 November 2014)

Health and Social Care Information Centre (2014a) *NHS provisional workforce statistics in England, non-medical staff*, London: HSCIC. Available at: www.hscic.gov.uk/catalogue/PUB15495/nhs-work-stat-july-2014-nur-area-levl.xls (accessed 11 November 2014)

Information Services Division Scotland (2012) *Admissions to mental illness specialties in Scottish hospitals*. Available at: https://isdscotland.scot.nhs.uk/Health-Topics/Mental-Health/Publications/2012-12-18/1218-AdmStatus-Dec2012.xls?77179683 (web) (accessed 14 November 2014)

Information Services Division Scotland (2013b) *NHS Scotland workforce - data as at 30th September 2013 - Nursing and midwifery staff in post*. Available at: https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/2014-05-27/Nursing_and_Midwifery_SIP_M2014.xls (web) (accessed 14 November 2014)

Information Services Division Scotland (2014a) *Annual statistics showing available beds by specialty and NHS board of treatment*. Available at: https://isdscotland.scot.nhs.uk/Health-Topics/Hospital-Care/Publications/2014-09-30/Annual_trends_in_available_beds_Sep14.xls (web) (accessed 14 November 2014)

Information Services Division Scotland (2014b) *Waiting times* https://isdscotland.org/Health-Topics/Waiting-Times/Publications/index.asp?ID=1172 (web) (accessed 14 November 2014)

Information Services Division Scotland (2014c) *NHS Scotland workforce June 2014* https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/2014-08-26/Nursing_and_Midwifery_SIP_J2014.xls

London School of Economics and Centre for Mental Health (2014) *The cost of perinatal mental health problems*, London: CMH. Available at: www.centreformentalhealth.org.uk/pdfs/Costs_of_perinatal_mh.pdf (accessed 11 November 2014)

Lintern S (2013) Francis effect leads to thousands more nursing posts, 20 October 2013 *Nursing Times.net*, www.nursingtimes.net/nursing-practice/specialisms/management/exclusive-francis-effect-leads-to-thousands-more-nursing-posts/5064458.article (web) (accessed 14 November 2014)

Lintern S (2014) Mental health patients sent hundreds of miles for a bed, 15 August 2014, *Health Service Journal*, p4-5.

Mental Health Foundation (2014) *Mental health statistics*. Available at www.mentalhealth.org.uk/help-information/mental-health-statistics (web) (accessed 17 November 2014)

Mind (2013), *Mental health crisis care: commission excellence for Black and minority ethnic groups*, London: Mind. Available at: www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf (accessed 14 November 2014)

Monitor and NHS England (2014), 2014/15 *National Tariff Payment System*, London: Monitor. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-Revised_26_Feb_14.pdf (accessed 14 November 2014)

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2013) *Patient suicide: the impact of service changes. A UK wide study.* Manchester: University of Manchester. Available at: www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/impact_of_service_changes.pdf (accessed 14 November 2014)

NHS England (2014) *Average daily available and occupied beds time series*, www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Beds-Timeseries-2010-11-onwards-Q4-revised-on.xls (web) (accessed 14 November 2014)

NHS England (2014a) *Five year forward view*, London: NHS England. Available at: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 14 November 2014)

Rethink Mental Illness (2014) *Lost generation: why young people with psychosis are being left behind, and what needs to change*, London: RMI. Available at: www.rethink.org/media/973932/LOST%20GENERATION%20-%20Rethink%20Mental%20Illness%20report.pdf (accessed 14 November 2014)

Royal College of Nursing (2013) *Improving outcomes for children and young people with severe mental health conditions*, London: RCN. Available at: www.rcn.org.uk/publications (accessed 14 November 2014)

Royal College of Nursing (2014) *Welsh Government consultation document policy implementation guidance: mental health services for prisoners in Wales*. Cardiff: RCN. Available at: www.rcn.org.uk/__data/assets/pdf_file/0007/562471/Mental_Health_Services_for_Prisoners_in_Wales_.pdf (accessed 14 November 2014)

Royal College of Psychiatrists (2013) *Bridging the gap: the financial case for a reasonable rebalancing of health and care resources*, London: RCP. Available at: www.rcpsych.ac.uk/pdf/Bridging_the_gap_summary.pdf (accessed 14 November 2014)

Royal College of Psychiatrists (2014) *Royal College of Psychiatrists' statement on mental health payments system (formerly Payment by results)*, London: RCP. Available at: www.rcpsych.ac.uk/pdf/PS01_2014x.pdf (accessed 14 November 2014)

Welsh Government (2013) *Admissions of patients to mental health facilities in Wales, 2012-13 (including patients detained under the Mental Health Act 1983) and patients subject to supervised community treatment*, Cardiff: Stationary Office (SDR 188/2013). Available at: http://wales.gov.uk/docs/statistics/2013/131030-admission-patients-mental-health-facilities-2012-13-en.pdf (accessed 14 November 2014)

Welsh Government (2013a) *NHS beds by specialty*, https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/NHSBeds-by-Specialty (web) (accessed 14 November 2014)

Welsh Government (2013b) *Non-medical staff, nursing staff by area of work* https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/Nursing-Midwifery-and-Health-Visitors/NursingStaff-by-AreaOfWork-Year (web) (accessed 14 November 2014)

Royal College of Nursing

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

November 2014

RCN Online
www.rcn.org.uk

RCN Direct
www.rcn.org.uk/direct
0345 772 6100

Published by the Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

020 7409 3333

Publication code: 004 772