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EDITORIAL

Funding for mental health care in England – still the poor relation?

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The financial woes of the NHS have been headline news over recent months. In the last three financial years, the financial health of the NHS in England has significantly deteriorated. From a £592 million surplus in 2012–13, finances declined to a £91 million deficit in 2013–14 and halfway through 2015–16 three quarters of trusts were in deficit with an overspend that could rise to around £2.5 billion or more.

Meg Hillier MP, Chair of the Public Accounts Committee, said recently 'There is a long way to go before the taxpayer will be convinced there is a workable and properly costed plan in place to secure the future of our health service'.

There is some evidence that mental health trusts have shouldered a disproportionate burden in these difficult financial times. The King's Fund recently analysed mental health services across England (The King's Fund, 2015) and found that around 40% of mental health trusts experienced a cut in income in 2013–14 and 2014–15. This was is in contrast to the acute sector, where the majority of trusts saw their income increase over the same period.

Consequently, mental health trusts are seeking to reduce costs through implementing reforms. However the King's Fund briefing notes that these often consist of a move away from services with an evidence base to care pathways and models of care for which the evidence is generally less clear (The King's Fund, 2015). Additionally, there is often little formal evaluation of the impact of these service changes.

Helen Gilburt (King's Fund mental health policy fellow) said that Mental Health Trusts were looking to transformation programmes to save money by moving care from the hospital to the community, focusing on self-management and recovery. She said 'Whilst few would dispute the intention and rationale for this – the problems

arise with the scale and pace of the changes, which lack the necessary checks to evaluate their effectiveness and the impact on patient care'.

Also in the news recently is that, in England, around 500 mentally ill people have to travel over 50 km (31 miles) to be admitted into hospital every month, a situation described by Professor Sir Simon Wessely, President of the Royal College of Psychiatrists, as a 'scandal'. This group of mentally ill people who have to travel significant distances to be admitted includes those requiring treatment within locked settings including low secure units (LSUs) and psychiatric intensive care units (PICUs). This dislocation of vulnerable patients from their local services, home areas and families is a serious concern. Clinically, professionals familiar with this situation identify that the geographical separation is rarely anything other than detrimental to aspects of care.

In understanding the issues, a recent report by the Commission to review the provision of acute inpatient psychiatric care for adults (Commission of Acute Psy-

chiatric Care, 2015) highlighted the problem of delayed discharges or lack of alternatives to admission as a symptom of far more widespread problems in the functioning of the whole mental health system. The report recommended that significant changes should be made to the commissioning, organisation and monitoring of mental health services and proposed the introduction of firm targets for improvement combined with new approaches to quality, data management, innovation and investment.

Here at the *Journal of Psychiatric Intensive Care* (*JPIC*) we recognise that specialist services such as PICUs and LSUs are part of a whole system. They are relatively resource intensive and their cost and specialised role means that they cannot be co-located with every acute inpatient unit. Nevertheless, they should be readily accessible to the populations they serve and travelling distances should not be excessive.

Staff working in PICUs and LSUs will applaud many of the proposals in the Commission's report. In particular, here at the *JPIC*, we believe that the content of our publications will help professionals to deliver the development of quality, safety and innovation required in this area of psychiatric practice.

In this issue, on the theme of quality of care, Wood & Alsawy (2016) publish a systematic review of qualitative evidence on patient experiences of psychiatric in-patient care. They identify three key themes associated with a positive experience of in-patient care: collaborative and inclusive care, positive relationships, and safe and therapeutic environments.

On the theme of safety and innovation, Rose & Slack (2016) identify the paucity of research on physical examination of patients post-restraint. They propose guidance on best practice in this neglected area of research.

Elsewhere in the issue, Haw & Kotterbova (2016) publish an interesting article on how PICU nurses spend their time. Whilst a significant amount is spent in patient contact, very little time is spent in direct therapy and it's interesting to note that 14% of their time is occupied with completing tasks that could be done by others, such as administrators.

Long et al. (2016) report their findings on a method for managing disturbed behaviour – training in de-escalation – and find it to be an effective alternative to restrictive interventions in a secure service for women.

Good reading!

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