Funding and staffing of NHS mental health providers: still waiting for parity

Author
Helen Gilburt

In 2013 the government made a commitment to achieving parity of esteem between physical and mental health. That commitment was followed by a pledge of £1.25 billion for child and adolescent mental health, a national strategy for adult mental health and an investment of £1 billion to support its delivery.

Parity of esteem means equal access to effective care and treatment, equal efforts to improve the quality of care, equal status within health care education and practice, equally high aspirations for service users and equal status in the measurement of health outcomes. Achieving parity requires action at multiple levels. Fundamental to this is ensuring adequate funding and staffing to provide safe and effective care and to deliver the vital improvements outlined in the The five year forward view for mental health [Forward View for Mental Health].

This briefing considers the current situation based on:

- an analysis of the annual financial accounts of NHS mental health, acute and specialist provider trusts
- an analysis of the national workforce data
- a review of the Care Quality Commission (CQC) inspection reports for each of the 54 NHS mental health trusts
- a review of the board papers of eight mental health trusts covering a six-month period from January 2016; the trusts were selected to include the four with the greatest increases in staffing over this time and four with the greatest decreases and to include trusts from each of the NHS England regions.

Parity of funding

Like other spending in health, the greatest proportion of funding for mental health care is allocated to NHS England. Much of this in turn is allocated to local clinical commissioning groups (CCGs) and via NHS England’s national programmes to fund the provision of mental health care. Introduction of the Mental Health Investment Standard in 2015/16 requires CCGs to increase investment in mental health services in line with their overall increase in allocation each year. In 2016/17, 85 per cent of CCGs met this commitment.

Several different organisations provide mental health care, including the private and third sector and spending from CCGs covers all of these. However, the NHS accounts for more than 80 per cent of secondary mental health care provision, most provided by mental health trusts. Some mental health trusts may receive additional income from other commissioners to provide mental health care such as NHS England for specialist services, or local authorities eg. for drug and alcohol services.
number of mental health trusts also provide community health services such as district nursing which they receive additional income for. This is not dissimilar to the income of acute and specialist provider trusts, and who also provide community health services. Given the key role of mental health trusts in providing mental health care and that many of the commitments to improving mental health care outlined in the Forward View for Mental Health relate to services provided by NHS mental health trusts their income provides an important marker of the ability to deliver that care.

The King’s Fund’s own work analysing NHS trust annual financial accounts has shown that approximately 40 per cent of mental health trusts received a reduction in their budgets in cash terms in 2012/13–2013/14 and 2013/14–2014/15, rising to almost 50 per cent in 2014/15–2015/16. This is in spite of the commitment to parity of esteem and the subsequent introduction in 2015/16 of the Mental Health Investment Standard. The latest data for 2016/17 shows that that situation has significantly improved, with 84 per cent of mental health trusts receiving an increase in funding in cash terms (Figure 1).

Figure 1

Comparative data obtained for acute trusts shows that over the same period approximately 85 per cent received increases in their income, falling to just under 75 per cent in 2014/15–2015/16. Like mental health trusts, the latest data for 2015/16–2016/17 shows a significant improvement, with almost 95 per cent of acute trusts receiving an increase in income in cash terms (Figure 2).

Figure 2
Funding health care – income, growth and centralised funding

In order to reduce rising overspends in trusts, NHS England and NHS Improvement applied additional financial planning requirements to NHS providers in 2016/17. The Sustainability and Transformation Fund (STF) was established, a £1.8 billion ring-fenced fund administered by NHS Improvement, NHS England, the Department of Health and HM Treasury. Funding from the new fund was paid out quarterly, in arrears, based on each trust agreeing and achieving a financial target set by NHS Improvement.

Funding from the Sustainability and Transformation Fund made up less than 1.4 per cent of mental health trust income on aggregate. However, without this centralised funding, only 63 per cent of mental health trusts would have seen an increase in their income from the previous year (Figure 3).

Figure 3
Among mental health trusts this relatively small amount of funding has had a discernible impact, which is in part explained by the slow growth in income in previous years (Figure 4). Before STF funding, mental health trust income grew by 4.1 per cent between 2012/13 and 2016/17, with STF funding increasing growth to 5.6 per cent. In comparison, acute trusts have experienced a cumulative growth in income of more than 13.9 per cent over the same period, which increased to 16.8 per cent when the STF is included, further widening the funding gap between mental health and acute providers.

Figure 4

Balancing the books

It is important to remember that the purpose of the Sustainability and Transformation Fund was twofold: to incentivise good financial management and to reduce deficits and ensure provider sustainability by targeting support for emergency services and the operational costs associated with providing those services. This reflects an impetus to achieve financial balance and a recognition that the biggest deficits lay with acute providers. In both sectors, individual providers’ financial position has improved (Figures 5 and 6).

---

1 Adjustments have been applied to individual trust data to account for mergers and acquisitions, and where final accounts were incomplete or include more than one set of accounts as a result of transitions to foundation trust status.
Without this additional funding, 12 per cent of acute trusts would have ended 2016/17 in deficit (Figure 7), a similar proportion to the previous financial year (Figure 6); for mental health trusts it would have been 25 per cent (Figure 7). Without this funding there would have been a continuation in the year-on-year increase of mental health trusts in deficit since 2013/14 (Figure 6).
Figure 7

Allocation of NHS funding
As we have highlighted before, delivery of the *Five year forward view for mental health* (Forward View for Mental Health) relies on funding allocated via CCGs’ baselines. NHS England has established a line of reporting in the Mental Health Dashboard to track CCGs’ commitment to investment through the Mental Health Investment Standard. The commitment to delivering this at a national level is clear, as demonstrated by NHS England National Clinical Director Claire Murdoch’s pledge to step in if funding for mental health does not reach the front line. However, the recent call by NHS Clinical Commissioners for ring-fenced funding indicates that there are problems with ensuring that funding allocated to CCGs for mental health service development is used as intended. Two years after the standard was established, 15 per cent of CCGs had not fulfilled this commitment, and issues remain with the quality of data published in the dashboard and the transparency on where funding is actually being spent.

The Mental Health Investment Standard and the improvements it underpins represent a positive move towards parity of esteem and an area of investment that NHS England has committed to protect. However, at a national level, growth in CCG income fell in 2016/17. This was in large part due to the establishment of the Sustainability and Transformation Fund, which accounted for approximately a third of NHS England’s overall growth. The slow rate of funding growth for mental health trusts and the preferential use of the Sustainability and Transformation Fund to stabilise financial and operational performance has widened the funding gap between NHS mental health and acute providers. As a result, even where CCGs have met the Mental Health Investment Standard, the funding allocated for mental health trusts has not kept pace with that allocated for services provided by NHS acute providers. This may reflect current realities in the system but runs counter to ambitions of achieving parity between physical and mental health – and to the government’s mission to tackle the burning injustices faced by those who experience mental health problems.
The relationship between funding, services and workforce

The impact of slow funding growth on NHS mental health providers is evident in a number of ways. As previously shown, NHS mental health providers have focused on transforming care and restructuring services to reduce costs, to shift demand away from acute services and prioritise approaches that support recovery and self-management. This has prevented many mental health providers from falling into deficit, but the scale and pace of change, a lack of robust evaluation and an underlying focus on cost reduction has resulted in increased variations in care and reduced access to services.

Transformation of the mental health workforce has been a common component of these plans. A recent briefing paper by the NHS Confederation and Health Education England provides an overview of changes in the NHS mental health provider workforce in England. Recent years have seen a welcome growth in the number of psychiatrists but lower rates of trainees progressing through training, particularly into higher specialist training.

Most notable is the decline in nursing staff, with a 13 per cent reduction in full-time equivalent mental health nurses between September 2009 and August 2017. Our own analysis of the data (Figure 8) highlights that these reductions have been primarily within ‘other psychiatry’ – a category that captures staffing within inpatient care, where the number of nurses has dropped by almost 25 per cent. In comparison, there has been a small increase in the number of nursing staff in community services, but these have been insufficient to offset the aggregate fall in nursing staff overall.

Figure 8

As the number of qualified nursing staff has declined in ‘other psychiatry’, the number of nursing support staff (nursing assistants/auxiliaries and nursing assistant practitioners) has remained relatively stable. There has been a small but notable increase since 2014, so that since May 2016 the number of support staff has outnumbered the number of qualified nursing staff employed in these settings.
In community settings, numbers of nursing staff were relatively stable from 2011 to 2013; in 2014 there was a notable decrease in numbers while 2015 to 2017 has seen an increase. The total change in numbers, however, remains relatively small. The total number of nursing support staff in the community also declined by 18 per cent between July 2009 and August 2017.

A number of factors have contributed to this. Reductions in bed numbers since 2010 have resulted in a 13 per cent decrease in nursing posts in psychiatric hospital settings, with a limited number being redeployed in community teams. The changing nature of services in the community including integration and decommissioning of specialist community teams has also reduced staffing requirements, with specialists such as psychologists being spread more widely across teams.

The emphasis on ‘workforce redesign’ in the strategic transformation plans of mental health providers has had a major impact on staffing. The King’s Fund’s own analysis of these plans found that they commonly direct specialist skills and time towards clinical activities and delivering
evidence-based interventions, supported by the development of more generic workforce roles to support recovery-focused care. Steps to deliver these plans include changes in the workforce profile, with a reduction in specialist clinical staff and senior nurses and an increase in junior nurses, allied health professionals and non-clinical roles including assistant practitioners, technicians, peer support workers and volunteers. This change in profile was reflected in the plans submitted by providers to Health Education England that forecast reduced demand for qualified nursing staff and an analysis of responses to the Quarterly Monitoring Report survey of providers by The King’s Fund.

**The realities of staffing mental health services**

The current context of staffing and the financial constraints within which NHS mental health providers operate set the baseline for all future plans. In addition, providers are expected to ensure that the requirements of safe staffing are met and that there is capacity to meet demand and to support the delivery of planned service developments outlined in the Forward View for Mental Health. This represents a balancing of interests that define the safety and effectiveness of care and the wellbeing of the staff providing it.

The following sections outline some key components of workforce management, the key issues impacting safe staffing and quality of care highlighted by CQC inspections, and insights from trust board papers illustrating the actions being taken and their impact as organisations struggle to achieve the right balance.

**Recruitment, retention and absence**

Nationally, approximately 10 per cent of all posts in specialist mental health services in England are vacant. Mental health nursing forms the backbone of current and future mental health services. An analysis of vacant nursing posts conducted by the Royal College of Nursing found that vacancy rates ranged from 8.1 per cent in the north east to 25.7 per cent in London. Among the trusts we reviewed, all report high vacancy rates, with difficulties recruiting to specialist psychiatry posts, such as child and adolescent psychiatry, and local availability issues with health care support workers. However, the most notable vacancies are for nursing staff, with none of the trusts able to recruit sufficient nurses to meet established staffing requirements.

National staffing data shows an annual increase in nursing staff numbers from September to November, after which there is a continual decline (Figure 11). Although the rate of decline has slowed in recent years, the pattern remains and is replicated at trust level. The reflection of one board that ‘the trust is losing staff faster than it is able to recruit’ was not unique.
Embargoed until 00.01 16 January

Figure 11

Analysis undertaken for the [Mental health workforce plan for England](#) found that growth of nursing posts in mental health has not kept pace with other professions, but in addition the net effect of staff turnover is currently negative, leaving 4 per cent fewer mental health nurses employed each year. Where stated, voluntary resignation made up the largest proportion of leavers in the trusts we examined, with retirement the second largest. Staff sickness rates were a common concern, with stress and anxiety-related issues one of the most frequently stated causes of absence. Staff feedback in trusts also highlighted staffing issues, including recruitment, staffing levels and caseloads, as key areas of concern.

The mental health workforce plan identifies a range of measures that providers can take to improve recruitment and retention. Weaknesses in recruitment were noted by several of the trust boards we examined, with common areas for development including:

- widening the reach of recruitment rounds through social media and advertising at regional and national levels
- improving the responsiveness of recruitment and selection processes to reduce loss of newly appointed staff
- using return-to-practice schemes such as re-registration of nurses and opportunities for nurses to be employed as health care support workers
- incentivising recruitment – eg, a £50 incentive to current staff who encourage friends and family to apply for a job that results in a job offer
- recruiting nurses in training before they qualified.

A reliance on recruiting nurses before qualification suggests shortages of qualified nursing staff. The significant time lag between trainee nurses being recruited and gaining their qualification, however, meant that not all who accepted an offer started work, and even those who did start were subject to a period of ‘preceptorship’ during which they could not provide care unsupervised.
Safe staffing

All trusts are required to report safe staffing levels; however, there is less accepted evidence and guidance on appropriate standards for mental health settings than for acute hospitals. In practice, trusts must individually collect, interpret and prioritise information on factors that contribute to safe staffing. In the majority of cases, this focuses on inpatient wards.

Interim findings of the Carter Review have highlighted the importance of good workforce management practices, starting with trusts having a staffing establishment rate that is based on the number and skill mix of staff required and that takes into account factors that may influence staff availability, including training, sickness and leave. Among the trusts we examined, half report routinely going beyond planned staffing levels on a regular basis in order to meet the needs of patients, with ‘overfill’ rates on individual wards reaching over 300 per cent on individual shifts. This was particularly notable on night shifts and largely involved additional rostering of health care support workers. This may reflect the fact that staffing establishment rates are too low or that there are not enough available staff to meet need.

The most commonly reported factors affecting safe staffing levels were staff vacancies, sickness rates and the acuity of patients. A review of factors influencing safe staffing reflects the importance of patient acuity but finds little evidence to support what good looks like. Of the trusts we examined, ensuring the safety of people with disturbed behaviour through increased levels of observation was the most common reason for increased staffing levels, although the ability to meet the demand of caring for those with more complex needs, such as physical health conditions or support with activities of daily living was also noted.

The need for additional staffing was also influenced by a lack of access to, or insufficient capacity in, service settings for managing patients with high levels of acuity, including psychiatric intensive care units and seclusion facilities. Staffing to provide the appropriate level of care remained above planned levels until a more suitable placement could be identified.

All trusts we examined were reliant on the use of bank and agency staff to meet safe staffing requirements and to staff services more generally. The extent to which temporary staff are effectively meeting this demand is not clear, but in several cases trust boards note that insufficient availability of temporary staff meant that services remained understaffed.

One means of ensuring sufficient staff numbers was to substitute staff groups. Although this measure is often framed as part of an escalation plan for staffing inpatient wards, the regularity by which it was reported suggests it represented routine rather than exceptional practice throughout the period we reviewed. The substitution of registered nurses by health care assistants predominated, although one trust reports using registered mental health nurses to provide cover for health care support workers.

Further measures taken by trusts to meet safe staffing requirements may reflect organisational preference, in addition to capacity and capability at a local level. They included:

- substantive staff working extra hours and in some cases unplanned hours
- use of senior nurses in supervisory roles to deliver direct care, eg, ward managers
- ‘cross cover’ – taking staff from one service to backfill staffing for another
- preferential rostering of substantive staff and registered nurses to day shifts, with increased reliance on bank and agency cover at night.
Measures to improve understanding of what is required to ensure safe staffing levels remain under development at a national level, and the trusts we examined demonstrate differing approaches to appraising the factors that contribute to safe staffing. The Carter Review of mental health trusts found large variation in the levels of staffing and in the mix of registered and health care assistants, even in ostensibly similar types of wards. At the same time, they found significant use of bank and agency staffing, with some wards under their core establishment and over-reliant on temporary staff. Opportunities exist to improve workforce management through robust rostering practices but currently they are not routinely applied.

New roles and workforce transformation

Health Education England has identified the development of new roles as an option to support delivery of the Forward View for Mental Health. Our own analysis highlighted a focus on new roles and workforce transformation as part of trusts’ strategic planning. Although both form part of the changing models of care in mental health, they have also served as means for trusts to reduce costs.

Workforce plans of mental health trusts commonly aim to review and align roles with new models, and to re-think the skill requirements of multidisciplinary working. Among the trusts we examined in this analysis, all but one had either undertaken or were undergoing work to redesign pathways and develop new models of care. One was explicit that the changes would include a decrease in the overall workforce while the others have embarked on service transformations that have resulted in reductions in staffing, although the balance of clinical and managerial staff within this varies.

Many planned changes in new roles and skill-mix changes reflect a focus on workforce productivity, described by one board as ‘making use of limited resources’. Plans to develop flexible new roles include the ability to work across settings and support deployment in real time where there is most demand in the system. Several of the trusts were planning to develop specialist nursing roles including nurse prescribers, advanced nurse practitioners and physician associates, providing a substitute for some roles undertaken by doctors, particularly given shortages in some specialties, increasing access to care and preventing unnecessary referrals to doctors. Consideration of skill mix and the development of a more diverse workforce arose most frequently in relation to nursing roles.

New roles may offer opportunities, but they are not immune from the pressures and challenges facing other workforce roles. As one trust found, a change in staff skill mix and the development of a new support role across community services had to be abandoned when concerns were raised about high caseloads among clinical staff, high turnover of staff in the new role, and poor clinical oversight of staff in the new role, including staff undertaking tasks that they were unskilled for. Subsequent actions taken by that trust included increasing the number of registered clinical staff while reducing the number of support roles to rebalance the financial model. The balance between clinical and non-clinical staff remains a key factor in effectiveness.

One of the most profound impacts on the workforce in the trusts we examined was the recommissioning and tendering of services due to the scale of changes involved. New services and contracts transferred between providers, for example, could substantially increase demand for staffing – resulting in a reliance on temporary and locum cover in the short term. In contrast, the loss of contracts had afforded trusts an opportunity to redeploy staff to fill vacancies elsewhere in the organisation. Uncertainty of future commissioning intentions could also have a negative impact on recruitment, and as one board notes, ‘balancing the operational pressures associated with employee transfers alongside the needs of the rest of the organisation and delivery of strategy has been challenging’.
Impact on quality and safety of care

The Care Quality Commission (CQC) highlighted staffing shortages in mental health services and the impact of this on quality and safety of care as one of its key areas of concern. Our analysis of CQC inspection reports found that problems with the staffing of mental health services were identified as a contributing factor to the safety of the care provided in over half of the mental health trusts. Many of the issues they identify reflect those highlighted in this analysis including: high vacancy rates, high staff turnover, a reliance on bank and agency staff, insufficient numbers of staff and inappropriate skill mix of staff. The most commonly reported impacts on providing safe care include:

- inconsistency of staffing and continuity of care provided to patients
- increased risk of suicide and self-harm on wards
- delays and cancellation of escorted leave from wards and therapeutic activities
- high caseloads in community teams limiting the time available to spend with patients
- delays in treatment and limited access to care in the community
- closure of beds due to staffing shortages.

The pressures on staffing were also evident among the trusts we examined, and while efforts are made to ensure that wards are staffed appropriately, exception reporting and implementation of staffing escalation policies were routine. Examples of risks flagged by boards included:

- in one month, nearly a third of duties in one trust were filled by bank and agency staff and nearly a quarter of registered nurses in post were newly registered
- wards were running with larger numbers of support workers to supplement gaps in qualified nurses
- bank staff were insufficiently trained in delivering care to service users
- there were shortages of substantive staff and reliance on agency staff not known to the trust and patients
- extra staff were very rarely available to enable an adequate response to incidents on one trust site
- there was instability in the management of a unit due to staffing changes including a new lead psychiatrist and secondment of the ward manager.

A review conducted by one trust of safe staffing comparing planned and actual staffing levels on each ward and the number of recorded incidents relating to patient safety concluded although that wards were usually safely staffed, this was not always the case. More than one board flags concerns about the difference between having a safe staffing level in which there are simply enough bodies to staff a ward with enough skills to carry out the necessary observations and having staffing that is sufficient to provide a really good therapeutic environment to support the recovery of service users. Like the CQC inspection reports, board papers of the trusts we examined included examples of how problems with staffing have led to:

- cancellation of patient activities
- insufficient staff to enable patients to take escorted leave
- inconsistency of regular substantive staffing having a negative impact on continuity of care and staff/patient relationships
- ward closures due to safety concerns including high numbers of patients absent without leave and assaults on staff as a result of insufficient staffing levels.
Many of these issues are also reflected in recorded complaints from patients considered by the board, and in some cases the trusts themselves are subject to CQC action as a result of staffing issues identified during the inspection process.

Impact on staff

A recent survey of staff working in mental health services found that of their 1,071 respondents, 74 per cent reported feeling stressed because of their work at least once a week, 36 per cent felt this way every day, and 22 per cent per cent had taken time off because of work-related stress in the past year. Staff shortages were reported by respondents as:

- a major factor preventing individuals from accessing services early (74 per cent)
- a reason for the increased frequency of violent incidents experienced in the past year (87 per cent)
- having to work unpaid overtime (57 per cent).

Although 67 per cent of respondents find working in mental health rewarding, over a quarter were considering leaving work in the sector due to the negative impact on their mental health and wellbeing.

Among the trusts we examined, insufficient staffing and the actions taken to manage safe staffing requirements were also seen to have negative consequences for staff, although this was not routinely monitored by all trusts. Monthly reviews of safe staffing in one trust found that staff routinely had to miss breaks including meals (although this time was given back in lieu), and that staff training and development sessions had been cancelled due to lack of cover. Those reviews also showed that the provision of direct care by senior staff negatively affected their supervisory duties, management and leadership responsibilities, and when used on a routine basis, cross cover could undermine teamworking and staff morale.

The impact on staff is also reflected as part of the CQC inspection appraisal of safe care. Inspection reports identify the negative impact of staff shortages on morale, staff working longer than their contracted hours to deliver care to patients and difficulties accessing training as a result of high workloads. High caseloads arise as a repeated issue in community services, and staff report concerns about being able provide safe, timely and effective care for the people they were supporting as a result.

The future of the mental health workforce

Providing high-quality care to patients requires two things: first, that NHS trusts have the revenue to recruit and retain the correct mix of staff, and second that these staff exist and want to work for the NHS. Our analysis highlights that there are underlying issues with the supply and availability of key staffing groups in mental health. Investing in the skills, job satisfaction and wellbeing of our current workforce should be a priority, but we must also invest to ensure sufficient workforce capacity.

The link between trust income and the mental health workforce is inextricable. All the trusts considered in this analysis report the use of temporary staffing as one of the most significant pressures on their financial position. There were some examples of trusts having received additional funding to ensure safe staffing requirements and in other cases ongoing negotiations, not all of which had been successful.

At the same time, trusts must deliver annual cost savings, and a key area for achieving this is workforce management. Reductions in whole-time equivalent staff and the maintenance of vacancies are each raised as options for cost improvement programmes. In one trust, options for
achieving short-term savings included closing a ward and re-allocating consultants to posts currently being filled by agency staff, reviewing use of observation levels to reduce use of agency and bank staff, and making beds available for out-of-area placements despite an acknowledgement of no additional staffing capacity. There is an obvious challenge in balancing the need to achieve cost improvement targets with the provision of safe and effective care. As one trust board notes, with less assurance that further cost savings can be delivered they are ‘reviewing major workforce changes... and the options to change organisational form through potential merger and acquisition opportunities’.

There is a temptation to tackle staffing challenges by re-shaping the workforce, but this should be treated with caution. The evidence on safe staffing of inpatient wards highlights the importance of ensuring an adequate number of regular, qualified staff with the skills to foster effective therapeutic relationships. That evidence has largely focused on the role of nursing staff; there is scope for exploring the potential for engaging the wider clinical team, but the impact on the quality and safety of care is unknown. This caution extends to community services, perhaps even more so given the emphasis on workforce re-shaping within the wider context of service re-configuration. As the Carter Review has identified, there is limited consistency in the staffing and delivery of care in community settings, and what constitutes an effective workforce is not yet clear.

Conclusion
Providing treatment and care relies on a good workforce; this is particularly the case in mental health where staffing overwhelmingly constitutes the main resource. This requires two things: for a trained workforce to be available and for employers to have the money to pay them.

Our work demonstrates that NHS mental health trusts are struggling to staff existing services on a day-to-day basis and, while actions to implement routine safe staffing levels are evolving, the lack of available staff, particularly nursing staff, at a national level continues to undermine this. Recent announcements of an increase in clinical placements for nursing students are welcome but these do not address the numbers of nurses entering training and will not fulfil demand in the short term.

Growth in income for mental health trusts did rise in 2016/17. However, despite the implementation of the Mental Health Investment Standard many trusts continue to see reductions in their income, which places constraints on staffing secondary mental health services. The priority being given by national leaders to expanding the mental health workforce is not yet being matched by a priority to ensure there is sufficient growth of income among NHS mental health providers to support this, nor to matching the growth in funding available to acute providers.

A vicious circle exists between the availability of trained staff and investment to support that workforce. The workforce plan to support the Forward View for Mental Health will further stretch this with 21,000 new posts to be created by 2021, 11,000 of which are ‘traditional’ regulated professions, such as nurses, occupational therapists and doctors; it requires providers to pull every lever to deliver.

While the emphasis remains on allocating funding to support financial sustainability and improve performance in acute hospitals, the gap between growth in funding for NHS mental health providers and that for NHS acute providers will continue. Commissioners, providers and boards alike also need to be honest about where their priorities lie and what impact this will have on care.

At its core, the commitment to parity of esteem is for people with mental health problems to receive the same quality, safety and effectiveness of care that people with physical health problems can
expect. Any change that is achieved at the expense of this commitment will ultimately fail to deliver parity.