BRITISH BROADCASTING CORPORATION RADIO 4

TRANSCRIPT OF "FILE ON 4" – *"MINDING THE GAP: MENTAL HEALTH"*

CURRENT AFFAIRS GROUP

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MUSIC

PRICE: He ran to the edge of the car park and he said, 'They are tormenting me, Linda.' And then obviously I heard the thud on the floor, I mean, I knew he had gone, I knew, and I mean, it was like nothing, there was like a deadly silence.

GOLDBERG: The despair of a wife whose husband killed himself after waiting three weeks for a psychiatric bed, which never became available.

PRICE: All they had to do was keep him in a safe environment until his psychotic symptoms had declined, but they didn't do that. If they had just kept him safe, then my husband would still be alive today.

GOLDBERG: Tonight on File on 4, fewer beds for mentally ill patients and inadequate support in the community. In the aftermath of the election, there'll be challenges ahead for the NHS in England, but nowhere more so than in the field of mental health. The Prime Minister has already promised equality with other forms of healthcare, what's called parity of esteem, but in reality, how easy will that be to deliver?

SIGNATURE TUNE

ACTUALITY IN HOSPITAL

EDELMAN: We are walking down the stairs and across the corridor we are going to go to Finsbury ward, which is the male treatment ward.

GOLDBERG: What kind of patients are in here?

EDELMAN: The patients in Finsbury ward are male patients. Usually they're suffering from psychotic disorders; they might be hearing voices or having sort of strange thoughts about things, like imagining that people are trying to kill them. I am just unlocking the door and this is the ward.

GOLDBERG: Patients playing snooker by the look of it – or pool – at the bottom.

EDELMAN: Yes, that's right.

GOLDBERG: A male inpatient psychiatric ward at St Anne's in Haringey which, like many other hospitals dealing with mental illness, is bursting to capacity and sometimes beyond it.

ACTUALITY WITH PATIENT

MALE PATIENT: I've been here for two weeks.

GOLDBERG: And have you been an inpatient before?

MALE PATIENT: Yeah, I've been in services since 19 and I'm 34 now.

GOLDBERG: What help do you get in the hospital that isn't available to you when you're outside?

MALE PATIENT: Right now I'm getting emotional support from the nurses. I'm getting emotional support from the psychologist. The doctors are involved in my care and the actual system has helped me and I'm on a good tablet now.

GOLDBERG: The majority of people on this ward have been detained under the Mental Health Act because they represent a threat either to themselves or to others. There are 25 patients under the care of the staff here, but just 19 beds and the pressures are similar on other wards.

ACTUALITY ON FEMALE WARD

EDELMAN: So this is a bit like the other ward, with an area at the back which is used as meeting rooms, there's a clinical room and the ward manager's office. This is the female ward on this side.

FEMALE PATIENT: I suffer from hearing voices.

GOLDBERG: What is it like, hearing voices?

FEMALE PATIENT: It's a bit like a long playing record that never ends. It seems to repeat the same things over and over again, and then I see things, like there's a shape of something there.

GOLDBERG: So you kind of have hallucinations as well?

FEMALE PATIENT: Yeah, but I learn to try and live with it most times. But from here hopefully they'll send me to a recovery house, because I'm trying to get into supported housing.

GOLDBERG: As well as permanent discharge, overcrowding is avoided by allowing some patients back home for a short period under supervision. Although if they relapse, a bed then has to be found – somewhere - back at the hospital. For psychiatrist Dr Katrin Edelman, clinical director for Haringey, it's a constant juggling act.

EDELMAN: We calculate our beds on a Trust-wide basis and as a Trust going across three boroughs; we have got 142 acute beds now. It seems not very many.

GOLDBERG: What does this mean on a daily basis in terms of pressure on beds for you?

EDELMAN: Well, on a daily basis, we have set up a military style bed management operation, the best way to describe it, so that every morning each ward has a sort of planning meeting, where possible people who could be discharged or sent on leave are discussed. There is then a Trust-wide bed teleconference at 11o'clock every day and then another one at 3 o'clock in the afternoon, at which sort of discharges and bed availability is discussed across all the wards. On occasion we have opened an additional ward, which has up to, I think, 14 or 16 beds, which is based in one of our hospitals at Chase Farm. When that ward is reopened, it is staffed from our other wards, so it places pressure on the staffing levels and agency staffing levels on our existing wards, and it is not an ideal arrangement.

GOLDBERG: Over the last five years, Barnet, Enfield and Haringey Mental Health Trust, has made cuts of £56million – an average of 6% a year. It's not unique in that, nor in the fact that bed numbers have been reduced. From the 60s onwards there has been a process of deinstitutionalisation, a belief that patients are better off treated in their own homes, among the support networks of family and friends. But many mental health professionals think the process has gone too far and that it's now being driven by finance, not philosophy. One study found that between 1998 and 2012, the number of mental health beds in England shrank by 15,000 – a cut of 39%. Latest estimates suggest that in the last three years, another 2,100 beds have been lost. It can mean that patients in crisis are denied admission to a hospital ward - sometimes with tragic consequences.

ACTUALITY WITH LINDA AND DAUGHTER

PRICE: Which one's this, Emily?

EMILY: Tinkerbell.

PRICE: Uh huh.

EMILY: Tinkerbell ….

ACTUALITY OF LINDA PLAYING WITH EMILY

GOLDBERG: Linda Price with her three year old daughter. Less than two years ago, Linda was happily married to husband, Graeme, and the family were enjoying a comfortable life together in Bedfordshire.

PRICE: He was very educated, intelligent, you know, fun to be around. Got on with people, of all levels, a good family man. Very, very high achieving for his age, he had a good salary and yeah, he had everything going for him.

GOLDBERG: But in the summer of 2013 - shortly after taking on a new job - Graeme started showing signs of becoming mentally ill for the first time in his life.

PRICE: He came home from work after he had just chaired a big project board. He came home on the Tuesday saying he couldn't go back. Within two days he'd started to talk about conspiracy theories and cameras in the house and a surveillance van being parked outside. It happened very fast. By the Friday, that was three days later, I thought possibly that he was thinking of taking his own life, just the way he was starting to speak. But by the Sunday we realised that we were in a bit of trouble. Graeme was not communicating anymore; he started to look a bit scared. We got him to the hospital, I mean it was quite clear that at this point he was suicidal and actually they said that if he wouldn't stay voluntarily, they would section him for his own safety.

GOLDBERG: But that never happened. Instead, Graeme was admitted to a non-specialist assessment ward. Linda says she was told he would be observed there for a maximum of 72 hours before being admitted to a psychiatric hospital. Instead, he remained in the assessment unit for more than three weeks, because no dedicated mental health beds were available. Linda was shocked to be called in and told he was then being discharged, even though in her view there was no obvious improvement in his condition.

PRICE: The plan of care was always that he needed a bed, he needed care. Graeme was seriously ill, you know, he was a danger to himself. I didn't know also at that point in time that they hadn't risk assessed my husband. I didn't know that they hadn't actually done a formal care plan to decide what his treatment was going to be going forward. They just released him. That's all they did. They hadn't done anything.

GOLDBERG: Linda says that when Graeme was being discharged, she was promised that the local community mental health team would visit him at home three times every day. Although she wanted him to stay in hospital, Linda felt reassured by this promise of intensive community support, but became quickly disillusioned.

PRICE: That lasted 24 hours, despite the doctor telling me that it would last at least two weeks and then it would go down to two visits a day for a couple of weeks. Actually what happened was we had three visits the next day, then the day after we went down to two visits, and then by the end of the week we were on a visit every other day. I think we went a maximum of maybe three or four days without a visit at home in the second week. I mean, that promise just wasn't kept.

GOLDBERG: At home, Graeme's condition showed no sign of improvement. But having been advised that trips out would be helpful, ten days after his discharge Linda took her husband shopping with their daughter, Emily. As they were about to leave a multi-storey car park, Graeme suddenly opened the car door and fled.

PRICE: He ran to the edge of the car park and he said, 'They are tormenting me, Linda,' and just jumped straight onto the side of the car park. I went and got Emily and I held her up actually and said, 'Please don't do this, we love you.' He didn't even look like Graeme, all his face was contorted and he just looked different. Everything was deadly silent and then obviously I heard the thud on the floor. I mean, I knew he had gone, I knew, I knew, and there was like a deadly silence, you know, and that was that.

GOLDBERG: At the inquest into Graeme's death, the Coroner recorded a narrative verdict, saying he 'required treatment as an inpatient but no bed was available'. The Coroner criticised the failure to carry out a detailed risk assessment or coherent care plan, and this resulted in a lost opportunity to support Graeme. Last year,

GOLDBERG cont: South Essex Partnership University NHS Foundation Trust, which was responsible for Graeme's care, cut its adult mental health beds by 14%. In a statement to File on 4, the Trust extended its sympathies to Graeme's family and friends, and added:

READER IN STUDIO: We are committed to learning from serious incidents in order to strengthen clinical practice and to ensure patient safety going forward. As part of this, the circumstances surrounding Mr Price's care were thoroughly investigated, robust action was taken to address the issues identified and the learning was shared with clinical teams.

GOLDBERG: But Graeme Price's death reflects a wider issue about the availability of inpatient care for mental health patients. It's not just that there are many fewer beds. File on 4 can reveal new figures obtained under Freedom of Information, which show that if patients are admitted to a ward, they spend significantly less time there than they did three years ago. Anna Bradley is Chair of Healthwatch England, which submitted the FOI after launching a special inquiry into mental health.

BRADLEY: What we found was that the average number of bed days had reduced; from 2011 to 2014 it fell from 57 to 51 days, which is about a 10% fall, so people spending less time in hospitals. Our concern is that what's happening is those people are being lost between the mental health Trusts and community services, and we say that because of the work we have been doing on our special inquiry where we have been talking to the users of mental health services about their experience.

GOLDBERG: So the average inpatient was spending six days fewer in hospital than the average patient just three years earlier?

BRADLEY: Indeed. It isn't necessarily a bad thing for people to spend less time in hospital. Most of us would rather be in our own home environment. What is particularly problematic is if people leave institutions and they cannot get access to the support they need in the community. So this really is the single most important issue, is that package of follow-on support, that crisis care, access to someone kind of 24/7 who can help them when they feel that actually they are no longer able to cope.

GOLDBERG: But returns to the Health and Social Care Information Centre show that more than half the community care teams in England had less contact with patients last year than they did the year before, even though more people were referred to them. Regular contact between care workers and patients, especially in the first few weeks after discharge, is often the key to a successful recovery and to preventing harm to patients. Professor Louis Appleby is Professor of Psychiatry at the University of Manchester and a former mental health "czar".

APPLEBY: The maximum risk of suicide is when patients first leave hospital and it sounds counterintuitive in the sense that that ought to be a time of recovery, but if you think about it, it probably also is a time when people are returning to the circumstances that they may have found difficult and they are leaving a relatively protected environment, which is the ward. So on the point of discharge, people take quite a significant step down in the protection that the services offer them and yet their risk may only gradually be declining, and so that balance of risk and protection swings towards risk.

GOLDBERG: Professor Appleby is now Chair of the National Suicide Prevention Strategy Advisory Group.

APPLEBY: The number of mental health patients who die by suicide is around 1,300 per year, it's about a quarter of all suicides across the country, and that number has been higher in recent years than it was five or ten years ago.

GOLDBERG: Can we divide those suicides between those who are having inpatient treatment and those who are having community care?

APPLEBY: The number of people who die by suicide while they are inpatients has fallen fairly dramatically over the last ten or fifteen years. Now the figure is around 70 patients a year, so that's less than half the figure that we would have found a decade ago. It is still 70 lives, it is still 70 bereaved families, but it is quite a bit less than it used to be. So the fact that the figures are generally higher for all patients means that that increase has mainly been in people who are having their care in the community.

GOLDBERG: And the increasing rate of suicide amongst mental health patients in the community would suggest either that the wrong kind of patients are sometimes being put back into the community, or that the community services that are provided for them aren't up to the job?

APPLEBY: I think mental health has a good record of dealing with safety in a way that maybe doesn't get recognised at times, but that is not to say that there aren't unacceptable pressures as well, and at the moment the fear is that that combination of financial pressures and the drive to the community. Which has a sensible evidence-based origin, but maybe at times be overdone, that that can mean that we go too far in cutting beds, we go too far in reducing length of stay, and that doesn't necessarily mean that community care as a whole becomes unsafe, but it might be that there are certain pinch points in the system which are really under pressure and run the risk of providing the wrong care to people. And those pinch points in mental health are very often the point of admission and the point of discharge from hospital.

CLYMO: Lorna was funny, kind, happy, a mum, a carer, just generally just a happy, bubbly person.

GOLDBERG: Sharon Clymo's sister, Lorna, had suffered depression on and off for twenty years. But her condition took a turn for the worse and in January last year Lorna attempted to take her own life.

CLYMO: She took an overdose and then was admitted to A&E. A few days later, Lorna came home on that occasion. There were just nothing there, you could see, you know, the conversation with her was very limited and she had always been a bubbly, happy person, but there was just nothing there, nothing at all, you know, and she just sat with her arms folded, and that was, like, soul destroying. Then the next time she tried to hang herself in the garage, and nearly succeeded, dislocated her shoulder, broke her thumb. I saw something that I never saw before - a sadness. That is why we needed help from professional people, because we were a little bit scared and I felt out of my depth, and so did my parents and her partner. It was different, we needed help.

GOLDBERG: Having made two attempts to take her own life, Lorna was again admitted to the Airedale Centre for Mental Health in West Yorkshire. In her medical notes, a nurse observed that she wasn't improving and concluded that she was likely to make another attempt on her life. Despite that, she was discharged again, having been an inpatient for just eleven days. She was given an emergency number to ring in the event of a crisis, and was placed under the care of the intensive home treatment team. But Sharon was concerned at the lack of consistency in her sister's home treatment.

CLYMO: Well, you never knew who was coming. She were more nervous of the people coming, because she didn't know them and she was going to have to tell them the same thing over and over and over. So what you are doing is, you're repeating yourself to the workers, the workers are listening, going away and then somebody else will come the next day. What is the point? They'd let her just, you know, just roam, just roam and do whatever she wanted. It were fatal, fatal.

GOLDBERG: Ten days after her discharge, Lorna's condition deteriorated.

MUSIC

CLYMO: It was a Sunday. My parents phoned me and said that they had been to visit Lorna at her house and Lorna was very agitated. She would lay down, she'd stand up, she'd go outside, she'd come back in. So I advised my mum to ring the number that they had been given, the emergency number, we needed help that day. My mum rang and rang and rang. No answering machine, no nothing, nobody got back to us. Do you know summat, there were nobody there. I just thought, you know, what are we supposed to do?

GOLDBERG: No one ever answered the family's desperate calls that day. The following Saturday, Lorna took her own life by jumping from a car park. Dr Andy McElligott, Medical Director of Bradford District Care NHS Foundation Trust, said that Lorna Clymo couldn't be kept in hospital against her wishes, because she didn't meet the criteria laid out in the Mental Health Act. But he added:

READER IN STUDIO: Our own investigation found that the out of hours service provided to Miss Clymo did not meet the expectations we, or Miss Clymo's family, would have expected. For this we are very sorry and we took immediate action to address this. Anyone experiencing a mental health crisis, or someone concerned for a person's mental wellbeing can now dial one number to speak to an expert who will quickly assess their need.

GOLDBERG: What's clear is that in recent years, despite a transfer of risk from inpatient care to community teams, funding for those teams has been cut rather than increased. We're talking about crisis resolution, early intervention and assertive outreach. Services which were originally established partly to counteract the decline in inpatient beds and spending on mental health overall fell in real terms by more than 8% during the last Parliament, despite a 20% increase in referrals. Much of this has come about because of decisions made at a local level by commissioners, but according to Chris Naylor from the health think tank the Kings Fund, there's also been pressure from the centre.

NAYLOR: One of the ways that the NHS has responded to the challenging financial environment over the last few years is by saying to hospitals and other healthcare providers that, 'We will pay you slightly less each year for providing particular things, like a hip replacement or some other element of care.' Now the intention of that is to put pressure on providers to become more efficient. The controversy that arose last year was that the guideline prices issued by NHS England suggested that across physical healthcare services, a 1.5% reduction in prices should be applied, but for mental health providers and community providers, the suggested reduction was 1.8%.

GOLDBERG: So mental health services were more harshly hit, they had to either do even more for less or make cuts in their services?

NAYLOR: Yes. At the same time that this was happening we have a debate around parity of esteem in mental health, so putting mental health on the same footing as physical health, and this guidance was seen to be in conflict with that.

GOLDBERG: The Kings Fund has estimated that in the last financial year, this funding difference led to a cut in mental health budgets of, very roughly, £32 million more than acute hospital services, contrary to pledges by politicians.

EXTRACT FROM SPEECH BY DAVID CAMERON

CAMERON: In terms of whether mental health should have parity of esteem with other forms of healthcare, yes it should, and we have legislated to make that the case.

GOLDBERG: The Prime Minister in March 2014. Yet, for the time being, parity of esteem remains more of an ambition than a financial reality. After decades when mental health services were underfunded relative to physical health, the gap has now widened. It's led to cuts in beds and community services, creating a perfect storm for one Trust in particular, the Norfolk and Suffolk NHS Foundation Trust, which in February became the first Mental Health Trust to be placed in special measures. Norfolk and Suffolk withdrew 93 beds, a quarter of their total, in just four years, whilst an aggressive redundancy programme also put pressure on community mental health services.

ACTUALITY ON STREET

BENTLEY: We're near St. Gregory's back alley and it's a place that my son has slept when he was homeless because of his mental illness, and it's a place where many other people congregate, homeless people.

GOLDBERG: Brenda has seen at first hand the decline in the service in Norfolk. She's a retired mental health nurse and her son Michael has suffered bouts of psychosis, one of which led him to threaten passers-by with ball bearings and a catapult.

BENTLEY: About five years ago, he was living in his own flat and he began to think that people were coming to attack him and he called the police. And the police brought him to us and eventually the crisis services locally came and interviewed him at home.

GOLDBERG: So what was the response then of the local mental health crisis team?

BENTLEY: Five years ago, the response was very good indeed. They attended that day; they were very reassuring to him. He went onto the psychiatric intensive care unit and received an excellent care plan and was discharged to a very good flat with supported housing workers there 24/7.

GOLDBERG: So that was five years ago, he had an episode of psychosis and was helped. What's happened since?

BENTLEY: When he became ill in that flat two years later, problems emerged. Because I very naively expected to have a similar response as I'd had from the Mental Health Trust in previous times, only to find that my emails and telephone calls were going unnoticed and ignored. In the absence of any effective psychiatric intervention of any sort from the Norfolk and Suffolk Mental Health Trust, the staff at the supported housing had had to call the police because he had threatened a neighbour with a knife.

GOLDBERG: After that episode, Brenda says that Michael was evicted from his sheltered flat. He was apparently too dangerous to be given housing, but not ill enough to be admitted to a psychiatric unit. Brenda says that even when Michael volunteered to become an inpatient in November, he was told there were no beds. And although he was told he needed home treatment, none was provided. Michael ended up sleeping rough before getting new accommodation in January. It was here, still suffering from paranoia, that he threatened his landlord with a knife and hammer.

BENTLEY: It wasn't as though that Trust did not know that when he was in the throes of deterioration, in his mental illness, that he became actively threatening and violent and that he would carry weapons. One of the weapons I have recently destroyed was a crossbow, for instance, and he had a foot-long machete. If left untreated, he is definitely a threat to other people, but there was no home treatment and there was no crisis intervention.

GOLDBERG: And do you believe that contributed to the moment when, just a few weeks ago, he threatened his landlord with a hammer and knife?

BENTLEY: Very definitely.

GOLDBERG: Michael has since been sectioned. Emma Corlett is a rep for the trade union Unison and works as a mental health nurse for the Trust. She's seen at first hand the impact of the cuts on her colleagues and patients.

CORLETT: To put it in context, in my 16 years of working as a mental health nurse I've had the misfortune of having to attend Coroners Court twice. I've had colleagues who've had to go five times in the last year. There are not enough of us to see the number of people that need our help. Also to be able to do our jobs effectively we need to be mentally resilient ourselves and have pride in our work and have the resources that we need to do. You know, staff sickness has gone up quite a lot over the last couple of years, because staff have been put through exactly the same pressures and stresses that bring people into our service in the first place. So, you know, it's not unusual to speak to colleagues in the community teams to say that, you know, they come in and find colleagues in tears or, you know, they're sitting in their car in the morning thinking, can I steel myself enough to kind of get through the door. And we've also had, you know, people that have become very unwell mentally themselves just through the stress of doing the work and the fear that they're not going to be able to provide the help that's needed.

GOLDBERG: Michael Scott was appointed Chief Executive at the Norfolk and Suffolk NHS Foundation Trust just over a year ago. He accepts there've been problems, but says they don't have enough money to do their job as well as they would like.

SCOTT: The national statistics suggest that mental health morbidity, that's illness due to mental health problems, accounts for something like 20% of the disease burden across the country. Whereas we get approximately 10% of all NHS funding, including that from CCGs, so half pro rata the disease burden. Our demand has gone up over the last four or five years, and even in the last year the number of referrals to us has almost doubled and at the same time, because of efficiency requirements, the funding

SCOTT cont: coming into the Trust has decreased. And as a result recently my Trust has turned in a deficit, and we have done that because we have prioritised spending on staff and on quality rather than balancing the books.

GOLDBERG: At the same time, you are the only Mental Health Trust in the country that is in special measures. Why is that?

SCOTT: My Trust tried to respond to the financial pressures, so there was a programme of transformational change, and that was only introduced because funding was being reduced. Had funding kept anything like at a level, that would not have been necessary, so I think you can track that back to the funding situation.

GOLDBERG: So essentially the need to balance the books was put before patient safety?

SCOTT: We have been very clear in the past, I think mistakes were made. We have apologised to people, that was the job that people were given, to both maintain quality and balance the books, but as I say, now we are currently overspending and we are doing that because we have deemed it more important to deliver quality.

GOLDBERG: At the heart of the problem is the way that mental health treatment is funded. Most NHS hospital care is paid for using a system known as payment by results where every treatment has a price attached. But in mental health, the system is less precise, with Trusts getting a lump sum to cover most of their work.

SCOTT: My organisation has been portrayed as the villain, but in actual fact we are the victim of funding policies which don't support improvement in mental health services.

GOLDBERG: Michael Scott again.

SCOTT: Mental health services and, come to that, community services as well are funded by a block contract in the NHS. Put very simply, what that means is we get the same amount of money every year, so irrespective of the work we do we might

SCOTT cont: see more patients, we do see more patients, we actually get the same amount of money year on year. The other system that is used is called payment by results and really that translates into payment by activity. So, put very simply, if acute hospitals see more patients, more people come through A&E, more people have operations, they get more money. Now that system does not apply in mental health, so it means even though we see more patients we in fact get less money. It is directly affecting mental health services and the many, many people who suffer from mental health conditions are not getting as much service as they might because of this funding mechanism.

GOLDBERG: Recognising the flaws in the block payment system, NHS England is moving towards so-called payment by results for mental health too. In this embryonic system, patients are defined as belonging to one of 21 "clusters" of care, reflecting the severity of their condition, with a price agreed in advance for each one. Payments would reflect a patient's entire journey through the health system. Whether on a psychiatric ward, being supported in the community or at their local GP. In time, this should become the basis of a national tariff. But while it's relatively easy to identify the cost of, say, a hip replacement or a cataract removal, operations with a defined beginning and end and a clear outcome, the same can't always be said of mental illness. Rowena Jacobs is a professor of Health Economics at the University of York.

JACOBS: This represents a really fundamental change to the way mental health services are likely to be funded in future. The price that will be paid for a particular condition will be agreed upfront, and what this does is it shifts the risk from the payer onto the providers. That cost will be based on the average cost of treating a patient, so for some hospitals their costs may be higher than the national tariff, and for other providers, their costs may be lower than the national tariff, so for some providers they effectively make a surplus on treating patients in that given cluster, while for others they might make a loss. It is going to incentivise providers to provide care in the most cost effective setting, so to try and effectively design care pathways which draw patients out of inpatient care, which is very costly, and try and keep them in the community for a longer period of time.

GOLDBERG: If you can somehow get a patient out into the community earlier, as a Trust you will be in surplus, you will be saving yourselves money?

JACOBS: Indeed. Of course, the danger of this is that if you discharge patients too quickly, you run the risk of running higher readmission rates, in other words, patients are discharged quicker and sicker, so they may need to be back in hospital before you know it. And if length of stay is cut too much, then it can have detrimental effects on patient care. So those are potential unintended consequences of a system like the tariff system.

GOLDBERG: So on the one hand there's the desire to create a new funding system which ensures a fair and transparent price for mental health providers based on a realistic assessment of the work they undertake. But on the other hand, there's a danger that hospitals could be incentivised to discharge patients too quickly. Dr Phil Moore is Chair of the Mental Health Commissioners Network for England and one of the people responsible for driving through payment by results.

MOORE: I think what we are trying to achieve is to be much more nuanced in the way that we are commissioning mental health. We have got to make changes that actually help people and support people, and I think this relates to the nature of the care in the community we give, not to the amount of it.

GOLDBERG: In terms of treating more patients in the community, that has been the direction of travel. What we've been hearing is that, in some cases at least, that community support is already failing.

MOORE: It isn't working in some places, and our job as commissioners is to say, are we investing the money in the right place? How do we shift the money so that we invest more in the community, so that people do get that right level of support? And to do that, we've got to change where we invest the money to make it effective for people who need that care within their communities.

GOLDBERG: The Department of Health wants an end to block contracts and for payment by results to become the default funding system for mental health. But in the current financial year, only 5% of Trusts expect to be paid that way by their commissioners. Why so few, if the aim is to accurately reflect the true costs of care? Phil Moore again.

MOORE: We are being very cautious about the way that we introduce this, both for the providers of mental health and for those of us who have to commission it, to make sure that neither of us break each other's bank, because that isn't the interests of our patients.

GOLDBERG: Isn't the danger, though, that it will end up placing greater financial demands upon the NHS, because the amount of activity that is out there at the moment might be far higher than is currently costed for?

MOORE: That's absolutely right, and that's part of the fear of commissioners with this change, what are we opening up here? Are we opening up a Pandora's Box of activity that we are unaware of that is suddenly going to make what's been set as the pricing on the basis of what we already know unaffordable in the future?

GOLDBERG: We did ask to speak to a Minister, but none was available. In a statement, the Department of Health told us that last year funding for mental health had been increased by £300 million, and this year, they expect commissioners to give a real terms increase to Trusts. There's the promise of payment by results too, although it isn't yet clear what impact that will have on budgets, or, more importantly, on the care of desperately ill patients like Graeme Price and Lorna Clymo.

SIGNATURE TUNE