

Research papers

Barriers and organisational development needs for effective primary care trust commissioning of mental health services

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ABSTRACT

Aims This paper reports the evidence base and expert opinion on the abilities and organisational development needs of primary care trusts (PCTs) to commission mental health services.

Methods Thirteen papers or reports relevant to the research aims were identified through the search strategy and twelve senior health service managers, clinicians and users (71% of those approached) agreed to the telephone interview.

Results The evidence base on commissioning identified five key barriers to effective commissioning from a PCT perspective, including a lack of resources particularly time and money, staff training needs, a lack of priority for mental health and commissioning at the grass roots level, issues around effective partnership working and the need for strong and informed leadership. The evidence base also identified four key areas that PCTs need to address if they are to be fit for purpose in com-

missioning mental health services including infrastructure changes, a skills training programme, mechanisms to encourage greater partnership working and a development programme that includes the new primary care mental health workforce.

Conclusions Although the evidence base suggests there are a number of barriers to overcome to achieve good quality PCT commissioning of mental health, many experts in the field are positive about the capacity and capability of PCTs to address the commissioning agenda and see it as an opportunity rather than a threat. PCTs now have the ability to commission locally focused and user-centred services that could lead to improved quality of life for a traditionally socially excluded sector of society.

Keywords: commissioning, evidence base, primary care trust

Introduction

Primary care has over a decade of experience of commissioning services since the introduction of the purchaser/provider split in the 1990 *National Health Service and Community Care Act*.¹ The general practice fundholding scheme and its subsequent variants such

as community fundholding and extended fundholding, total purchasing and locality commissioning gave many general practitioners (GPs) an opportunity to influence secondary care providers directly, so that by 1997 over 55% of the population was registered with practices who operated some form of fundholding.

The last five years have seen a further significant policy shift in terms of primary care roles and

responsibilities with *The New NHS: modern, dependable* formally announcing the demise of GP fundholding and the internal market and replacing it with a formation of primary care groups (PCGs) and more recently primary care trusts (PCTs).² Most recently, policy initiatives including *Shifting the Balance of Power* and *Shifting the Balance of Power: the next steps* have ceded responsibility for commissioning mental health to PCTs across England.^{3,4}

Although the *National Service Framework for Mental Health* and *The NHS Plan* had already highlighted the central role of primary care in developing good quality mental health services, the commissioning role is a significant additional key task both on an economic and an individual scale.^{5,6} Antidepressants account for 7% of the United Kingdom (UK) primary care drug budget and the total cost to the economy of people with serious mental illness and common mental health problems is greater than for those with ischaemic heart disease, breast cancer and diabetes combined.⁷ On an individual level, there are over 250 000 annual patient admissions and over 4000 people commit suicide in the UK each year.⁸

There are a number of theoretical and practical advantages in primary care-led commissioning of mental health services.⁹ Primary care is increasingly recognised as a major site of mental health activity where over 90% of people with mental health problems are seen and treated. Primary care commissioning of mental health services should enable the development of greater interface working and more locally responsive services. It should also broaden the agenda for mental health services to include, for example, social care and education. The PCT commissioning role might also increase the level of interest and involvement in mental health in primary care, which might in turn lead to better service provision at a grass roots level. There are, however, some concerns that the 'policy express' and unprecedented rate of change in the NHS in recent times may have created a climate where PCTs are ill-prepared for their new commissioning roles.¹⁰

This study therefore aimed to review the evidence base and gain expert opinion on the barriers and organisational development (OD) needs for effective PCT commissioning of mental health services.

Methods

The two authors reviewed the evidence base in both synthesised and non-synthesised formats from published and grey literature on the following databases from January 1995 to January 2002:

- Ingenta
- CINAHL
- Bids (Bath University ISI database)
- Science Direct
- Cochrane Reviews (Issue 1, 2002)
- National Research Register
- Department of Health Library and Information Services Database
- King's Fund Library Database
- HELMIS (Health Management Information Service)
- The University of York (NHS Centre for Review and Dissemination): Database of Abstracts of Reviews (DARE)
- Health Technology Assessment Database (HTA)
- NHS Economic Evaluation Database (NHS EED)
- British Library Public Catalogue.

The following websites were also searched for grey literature including government reports:

- King's Fund
- Department of Health website using the POINT (Publications on the Internet) and COIN databases (Circulars on the Internet)
- National Primary Care Research and Development Centre (NPCRDC)
- Sainsbury Centre for Mental Health (SCMH)
- North West Mental Health Development Centre (NWMHDC)
- Mental Health Resource Centre for England
- King's College London
- Audit Commission (government website)
- Primary Care Database
- Office of Health Economics (publications)
- The Stationery Office
- HSMC (Health Services Management Centre)
- Virtuall.org (Better Mental Health for London).

The search terms used were 'commissioning' (exploded) in association with mental health, primary care (groups and trusts), locality commissioning and fundholding. All titles and abstracts of papers identified by searches were scanned by both authors independently to exclude those that had no relevance to commissioning mental health. Complete copies of all remaining papers were obtained to identify all publications relating to commissioning in general, and to mental health care in particular. These searches were supplemented by a hand search of key journals (*British Journal of General Practice*, *Health Service Journal*, *Psychiatric Bulletin* and *Journal of Mental Health*), and by scanning the reference lists of all articles found through the above strategies. The papers and reports were read independently by the authors and analysed by selecting and reorganising emergent issues according to themes.

Box 1 Topic guide

- How should PCTs decide on their mental health commissioning priorities?
- What are the advantages/key strengths in PCTs commissioning mental health services?
- What problems/barriers do you envisage PCTs may encounter in commissioning mental health services?
- What is the role of PMS/PMS+ in developing better commissioning primary care services?
- How can we develop PCT organisational fitness to commission mental health services?
- What are the roles of users in developing services?

PMS: Personal Medical Services

The evidence base necessarily reflected views prior to the introduction of key policy changes such as *Shifting the Balance of Power*.³ Therefore, to gain an informed 'up to the minute' multidisciplinary view of PCTs and mental health commissioning, telephone interviews were conducted by HS in January 2002 with purposefully sampled key informants involved in mental health service delivery or development across England. Interviewees included users, senior representatives from health authorities, regional offices, PCTs, local implementation teams, community health councils and social services. The topic guide included questions that explored in depth their views on PCTs' ability to commission mental health services and PCT OD needs to become fit for this purpose (see Box 1). Interviews, which lasted between 20 and 30 minutes, were transcribed over the telephone by HS and to increase the trustworthiness of the data, all interviewees were sent a copy of their interview transcript within 24 hours to check for accuracy and confirm verbatim quotations. They were also sent a copy of the interim report and asked to comment on emerging ideas, and themes were revised in the light of their feedback. Themes were identified and developed by the authors from reading and rereading transcripts using a grounded approach.¹¹ Disagreements over subsequent coding of the interviews were discussed and resolved.

Results

Thirteen papers or reports relevant to the research aims were identified through the search strategy (see Table 1) and twelve people (71% of those approached) agreed to the telephone interview. Most interviewees

were positive about the concept of PCT-led commissioning of mental health services and expressed the hope that services would be both more locally responsive and patient-centred including greater use of a low stigma setting.

'If the focus and purpose of your role is to improve mental health for all people then the PCT is the best vehicle to do it. It's about citizenship and recovery, about offering a whole service. There is an issue of ownership; if mental health is part of mainstream policy then it is not marginalised. A PCT can link with external agencies and engage in a remit broader than treating mental illness.' (Interview 8)

Although a number of different issues were highlighted both in the evidence base (see Table 1 for details) and by experts in the fields, five main barriers to effective commissioning emerged from both written and verbal data sources.

Lack of resources

A lack of resources, specifically time and money, was the most frequently mentioned barrier to effective mental health commissioning.^{10,12-16} Poor information technology (IT) support for enabling the availability of accurate information both to perform a basic baseline assessment and follow up assessment was highlighted.^{17,18} This was exacerbated by a perceived lack of support from the health authorities in taking on commissioning tasks and insufficient time to allow staff to understand and operationalise the new agendas and functions.^{19,20}

'PCTs need headroom, they need a period of stability.' (Interview 7)

Staff training needs

Staff training needs were identified in all aspects of the commissioning process, particularly needs assessment, contract and finance skills and performance monitoring, and were perceived as a significant barrier to effective commissioning.^{13,17}

'I am worried about people having the power and the money to commission before they have the skills.' (Interview 3)

Lack of priority at the grass roots

There was also a perceived difficulty in motivating the 'grass roots' GP both in the commissioning agenda and mental health, and concerns that the breadth of the PCT commissioning agenda could mean that

Table 1 Details of the 13 included papers

Source	Methodology	Time frame	Perceived barriers
Hine and Bachman, 1997 ¹²	Postal questionnaire survey and interviews with GPs and health authority staff involved in locality commissioning	August–November 1996	<ul style="list-style-type: none"> • Lack of time • Lack of resources • Lack of information management and technology (IM&T) • Ambivalence from health authority • Lack of management leadership • Hospital consultants' lack of understanding of primary care • Motivating uninterested GPs • Slow pace of change • Lack of confidence in ability to change • Lack of cohesion among practices • Lack of support structures
Power, 1997 ¹³	Two-day open simulation about locality commissioning	February 1997	<ul style="list-style-type: none"> • Lack of time GPs have to devote to commissioning roles • Lack of resources • The need for training and some form of accreditation for GPs to undertake their new roles • Requirements of national policy • Pressures created by the NHS management processes
Douglas, 1997 ²⁰	Semi-structured interviews with 18 fundholders	September–December 1995	<ul style="list-style-type: none"> • Lack of time • Lack of management skills • Lack of leadership
Goodwin <i>et al.</i> , 1998 ¹⁴	Face-to-face semi-structured interviews in 52 TPP sites	Autumn 95–Spring 97	<ul style="list-style-type: none"> • Lack of time • Poor IT
Gask <i>et al.</i> , 2000 ²²	Semi-structured telephone interviews with 57 GP or project manager leads in 40 sites with a special interest in mental health	September 96–August 97	<ul style="list-style-type: none"> • Poor IM&T infrastructure • Limited user involvement • Few formal mechanisms in place to perform systematic needs assessments • Resources diverted from serious mental illness towards common mental health problems
Peck and Greatley, 1999 ¹⁷	Focus groups and surveys in three London sites, involving primary care and community mental health teams	1997/8	<ul style="list-style-type: none"> • Insufficient support to develop commissioning skills • Insufficient support to understand how to perform a need assessment
Regen <i>et al.</i> , 1999 ¹⁶	Semi-structured interviews and focus groups with GP, health authority leads, social services, directors of commissioning and uninformed personnel in 40 GP pilots	August–October 1998	<ul style="list-style-type: none"> • Lack of time • Lack of IM&T • Relationship with health authorities • Internal organisational issue • Need for a targeted programme of OD for board members

Table 1 (continued)

Source	Methodology	Time frame	Perceived barriers
Regen <i>et al.</i> , 2000 ¹⁸	Semi-structured interviews and focus groups and postal questionnaire to all GPs in 12 PCGs	July–August 1999	<ul style="list-style-type: none"> • Insufficient time to develop • Lack of IM&T • Requirement for more senior and experienced managers • Inadequate staff training
Audit Commission, 2000 ¹⁵	Interviews with 1 in 8 PCG chief executives and PCG board members and staff	July–September 1999	<ul style="list-style-type: none"> • Lack of time • Lack of resources • Lack of IM&T • Lack of support from the health authority • Poor GP engagement • Conflicts between local and central targets
Regen <i>et al.</i> , 2001 ²¹	Semi-structured interviews and focus groups and postal questionnaire to all GPs in 12 PCGs	September 1999–August 2000	<ul style="list-style-type: none"> • Lack of time • Lack of IM&T • Lack of support provided by the health authority • Insufficient management support • Strains with relationships with social services
Wilkins <i>et al.</i> , 1999 ²³	Semi-structured interviews with chief officers chairs, health authority leads and a postal questionnaire to four members with lead responsibilities in 72 PCGs	October–December 1999	<ul style="list-style-type: none"> • Lack of IM&T • Lack of help from the health authority • Differences in geographical boundaries, organisational structures and accountability arrangements present particular challenges to the development of effective partnerships between PCGs and local authority services
Sainsbury Centre for Mental Health, 2001 ¹⁰	Postal questionnaire to the 481 PCGs in England	January–February 2000	<ul style="list-style-type: none"> • Lack of time • Lack of resources • Poor IT systems • Lack of specific commissioning knowledge • The tension between providing services for the severely mentally ill at the expense of those with a common mental illness • Capacity of the PCG to manage the current change agenda
Wilkins <i>et al.</i> , 2001 ¹⁹	See above	October–December 2000	<ul style="list-style-type: none"> • Lack of money • Lack of IM&T • Lack of support from health authorities • Financial constraints and lack of management capacity

mental health was de-prioritised both at PCT board and grass roots level.¹⁵

'There needs to be a real consciousness raising among GPs about mental health.' (Interview 1)

Partnership working

There were also worries in terms of partnership working with other professional groups such as social services and mental health trusts with time and space acknowledged as being vital for staff to understand and appreciate the differences in culture between social services and health.²¹ Mental health specialists appeared particularly worried that PCTs would commission services for the 'worried well' rather than for people with serious mental illness.²²

'Well-meaning GPs may decide to listen to the views of service users who they feel most comfortable with and they might end up with aromatherapy provision but no crisis intervention.' (Interview 4)

There were also concerns that primary care would not involve service users in the commissioning process.²¹ The evidence base strongly suggested that user and carer needs should be at the epicentre at all stages of mental health commissioning because without this need there is no reason to have a service. However, there were worries that since many PCTs have still to develop the appropriate infrastructure and gain specific commissioning skills, user involvement may actually rapidly fall down the agenda in the short to medium term with no one tasked to involve them in the commissioning process.

'Users and carers can't just be dumped in a room and expected to get on with it.' (Interview 9)

The need for strong leadership

Engaging in and addressing all these agendas was recognised as a complicated task, requiring charismatic and committed leadership.^{12,20} However, structural NHS changes were perceived as diluting the pool of leaders capable of creating a clear and simple yet informed vision, and therefore of potentially blunting the beneficial impact of PCT mental health commissioning. Strong leadership was also seen as crucial in creating a culture of mutual respect within and between organisations and also in managing change at all levels of the organisation.²³

Telephone interviews with the 12 expert informants suggested that there are four key areas that PCTs will need to address if they want to be fit for purpose in commissioning mental health services.

Infrastructure changes

A PCT OD programme will need to address basic infrastructure issues if commissioning roles are to embed successfully in the new organisations. Resources to increase information and technology capacity, particularly electronic communication systems are vital in fulfilling the commissioning agenda.

PCTs also need to consider the fundamental issue of size. There were concerns voiced that smaller PCTs may not be able to address the commissioning of specialist services even if lead arrangements are in place. Co-terminosity with local authorities is also an issue that will need to be addressed, particularly if joint commissioning is envisaged.

'There is an issue about the size of PCTs and their ability to commission mental health services. We are successful but our PCT is over 250 000. For PCTs of 100 000 this might be a problem because they might not have the capacity.' (Interview 10)

However, this fear was balanced by the perceived advantages of smaller organisations in commissioning more locally sensitive services.

Commissioning a skills training programme

Most respondents expressed concerns about PCTs' knowledge of and skills in the actual commissioning process and, to a lesser extent, in terms of mental health services provision. Key areas where training is required for the PCT commissioning team include performing a needs assessment, evaluation and interpretation of evidence, finance and contract management skills, and selecting and interpreting outcome indicators to monitor the provision of care. Partnership working with public health was felt to be key to achieving these skills.

There were also concerns about the extent that PCTs understood the problems and intricacies of commissioning general and specialist mental health services and the particular issues related to successful participation in joint strategies for social care commissioning.

'Are people aware of the breadth of services they will have to commission for mental health?' (Interview 2)

'GPs in particular like instant gratification; their training gears them for it. They see a patient, make a diagnosis, write a script and/or refer to a specialist. It is an immediate service. What professional executive committees are trying to do is come to terms with thinking in 'long-term' strategies, and this is not without its problems!' (Interview 12)

Partnership working

The partnership between health and social care professionals and users was felt by all interviewees to be fundamental in commissioning appropriate holistic mental health services. Most interviewees also felt that PCTs will need to ensure they have mechanisms in place such as an annual survey measuring users' overall satisfaction with care, training programmes so that users and carers feel equipped to participate in the generic commissioning agenda and mechanisms so that briefings and user/carer opinions can be heard by commissioning managers. One interviewee suggested adopting integrated care pathways as a mechanism for monitoring service provision which would also enable users' experience to guide service developments.

'It's absolutely vital that we understand patients' journeys as they go through the services.' (Interview 2)

Workforce development programme

New workers such as the primary mental health workers and gateway workers were perceived as an increasingly important part of PCT mental health service delivery.⁶ PCTs will need to think through the deployment strategies, ongoing training programmes and career structures of these post-holders to maximise the potential of these new roles. *The NHS Plan* suggests the equivalent of one primary mental health worker for 50 000 of the population but many respondents felt that some PCTs may want to commission additional workers and/or training programmes with a particular focus dependent on the result of locality-based mental health needs assessments.⁶

Discussion

This paper describes the current evidence base and the views of experts in the field of primary care, mental health and commissioning on the barriers and OD needs of PCTs to commission mental health services. It is limited by the relatively small number of papers and reports in this field and the short time frame (four weeks) in which the interviews were conducted. However, the face validity of the findings is strong measured by the reception of the findings at presentations regionally and nationally in 2002 and the reliability is increased by the methodological triangulation of data sources and the rigour and transparency of the literature review process.

The review suggests that key barriers to commissioning and areas that PCTs need to address, if they are

to be fit for purpose in terms of commissioning mental health services, include appointing strong, informed leaders who can inspire the troops and think 'out of the box' when problems arise. PCTs will need to spend money on basic infrastructure such as electronic communication systems to gather appropriate information for effective commissioning. PCT staff need to develop generic commissioning skills such as how to perform a needs assessment, evaluate and interpret evidence, finance and contract management, and to understand the particular problems and intricacies of commissioning general and specialist mental health services. The regional specialised commissioning groups will be key partners in helping PCTs to understand good practice in this area. Finally PCTs need to understand the strengths and weaknesses of partnership working with social care organisations, with users and also when engaging primary healthcare teams and mental health trust providers.

There are a number of national organisations that have been put in place to help guide PCTs in their new commissioning roles. In addition to support from the regional National Institute for Mental Health in England development centres, the leadership centre, part of the Modernisation Agency has a programme specifically tasked with developing knowledge, skills, attitudes and vision of new PCT leaders.

The National Primary and Care Trust Development Programme (NatPaCT), established in the summer of 2001 following the publication of *Shifting the Balance of Power*, has been tasked with establishing a programme of organisational and personal development to support PCTs and care trusts to deliver on their core functions including commissioning.³ Current work includes developing a PCT competency framework as a self-assessment tool, and setting up significant issues to draw up advanced competencies in specified areas including mental health.

Structural change and outside support by themselves will not, however, be sufficient to make people work differently. People have to understand each others' cultures and build relationships based on trust and understanding. This may be particularly important in terms of joint commissioning between health and social care. It may come down to something as simple as regular face-to-face meetings and learning from each other, perhaps through shadowing and secondments. In particular, staff from the health authorities and public health are a significant source of expertise and have the knowledge and skills in this area to ensure continuity of knowledge and capability rather than simply business continuity.

The paucity of evidence on PCT commissioning of mental health services also suggests that further research is needed in this area to provide a more adequate evidence base to inform future PCT OD programmes. This could include consequences, such as

cost-effectiveness and patient satisfaction, of commissioning outcomes rather than service specifications.

Conclusion

Although the evidence base suggests there are a number of barriers to overcome to achieve good quality PCT commissioning of mental health, many experts in the field are positive about the capacity and capability of PCTs to address the commissioning agenda and see it as an opportunity rather than a threat. PCTs now have an opportunity to commission locally focused and user-centred services that could lead to improved quality of life for a traditionally socially excluded sector of society, although there are still tensions in terms of balancing this with the need to secure services in line with national mental health policy.^{5,6} PCTs need to be open about their strengths and weaknesses in this area and remember that time is an ally and is important in developing new working partnerships and common mental health agendas across user and professional interfaces.

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