

## Development and policy

# Commissioning and system reform: the bigger picture

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Good morning everyone and thank you for inviting me to your conference. I want to begin by telling you a story about someone travelling through the American mid-west. He is in a small town in the middle of nowhere, and plans to catch a train at 8.30 a.m. The clock outside the station says 8.25, so he thinks, 'Great, I've got time to get a quick coffee'. So he does that and he goes straight onto the platform only to see the train disappearing into the distance. And the clock on the station platform says 8.35. Obviously cross about this, he challenges the stationmaster about the clocks telling the wrong time. And the station master looks at him with complete bemusement and says, 'But what would be the point in my station having two clocks if they're both going to tell the same time?'

There is a kind of bizarre logic to that reply, but it put me in mind of the myriad of different policy instruments and levers across the NHS and wider public services and there is a real challenge in ensuring that collectively they achieve the equivalent of 'telling the right time'. What I will try to do in this presentation is to bring together the different strands of the current policy agenda to form a more coherent story about commissioning generally, how this connects with the wider system reform agenda and specific issues in relation to commissioning mental health services.

My own particular role is leading the Care Services Improvement Partnership (CSIP), established by the Department of Health last year to bring together several different improvement teams and initiatives into a single entity. Many of you will be aware of the work of our largest programme, National Institute for Mental Health in England (NIMHE), and I hope you will be familiar also with the work done by our Change Agent Team, with NIMHE colleagues, in relation to mental health and older people; and possibly the work of Integrated Care Network in disseminating

and supporting good practice in partnership working. We have a specific network for better commissioning. Essentially CSIP's role is to make policy work out there, and to support local service improvement, with a particular focus on involving users and carers. Uniquely we work across the National Health Service (NHS) and local government, covering the whole spectrum of care services including those for children, families and adults. Most of our work is delivered through eight regional centres, to make sure that our programmes can be tailored to local needs and circumstances. Further details about the many aspects of CSIP's work can be found on our website ([www.csip.org.uk](http://www.csip.org.uk)).

The current major planks of Government policy in relation to NHS and social care are set out below.



### The policy framework:

- Mental Health NSF (1999)
- NHS Plan (2000)
- Delivering the NHS Plan
- The NHS Improvement Plan (2004)
- 'Choosing Health' White Paper (2004)
- Creating a Patient-led NHS (2005)
- Commissioning a Patient-led NHS (2005)
- 'Your Health, Your Care, Your Say' consultation > White Paper

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It is tempting to conclude that what we need is not more policy, but better implementation. But we are getting more policy in the form of a new White Paper on community health and social care services which we expect sometime in January. And although that will be addressing largely mainstream issues in relation to the NHS and social care, it will

have implications for mental health as well as other parts of the NHS. There has been very extensive consultation over the summer and it will be a crucial document to look out for.

In reviewing the current policy framework it's interesting to reflect on what would have happened had the mental health National Service Framework (NSF) been published later on in this cycle, i.e. after the major investment of resources in the NHS signalled by *The NHS Plan*.

Embedded within the policy agenda are a couple of specific and very significant commitments that appeared in the Labour Party election manifesto. The first is about overall investment in mental health services, but linked to talking therapies, psychological therapies and Richard Layard's work. And the second is around the public protection agenda and the Mental Health Bill. It is incredibly significant that in a manifesto of a major political party there are two very, very explicit commitments in relation to mental health. It suggests that the proximity of mental health to the top of the public sector reform agenda is closer than it has been for a long time.

All of these policies are supported by the twin pillars of investment and reform. Investment – from a spend of £34 billion on the NHS in 1997, to £76 billion this year and by 2007/8 it will be £92 billion. By any standard this is a staggering increase in resources. Those of you who are working in mental health are entitled to ask the question, 'Well how much of that did get through to front-line mental health services?' The overall scale of the additional investment is indisputable. Reform – initially, from 1997 the emphasis was about establishing national standards through the NSFs, establishing independent inspection and regulation arrangements through the Health Care Commission and Commission for Social Care Inspection, and very top down, centrally driven approach to targets and performance management. And at one point we had over 400 targets against which local health organisations were being monitored. And as we entered the new millennium, there came a recognition that it was not appropriate to achieve sustainable improvement and change by that relentless top-down, target-driven approach. Instead, the emphasis has shifted towards 'designing-in' incentives for good performance into the way that services work and are funded. So what we have in effect is a system reform agenda that is very much about putting in place systems, processes, and result frameworks that enable local health systems to self-generate their own high performance rather than it being done in a top-down fashion from Whitehall. And the main planks of that system reform policy are Foundation Trusts, giving NHS Trusts more freedom to innovate, more flexibility

and control, to respond to local needs. Secondly, payment by results, the introduction of a national system of tariffs and financial flows, to bring in more transparency, and to ensure that money is better able to follow the patient. And the third major leg of the system reform tripod is practice-based commissioning. I know you're going to be hearing more about these things later on in more detail, but the key feature of practice-based commissioning is devolving resources and, crucially, decisions to as low a level as possible and closer to the point of need.

And underpinning all of that, of course, is commissioning the patient-led NHS proposals to reconfigure NHS organisations so that we've got more appropriately sized and fit for purpose bodies that are able to take on the challenge of managing this quite complex dynamic system that will evolve as a result of payment by results and practice-based commissioning. A system in which patient choice and contestability between providers are central. Taken together it represents a formidable agenda for change, one with risks as well as opportunities.

Although most of the system reform agenda does not directly affect social care, we should not overlook what is in effect the social care equivalent of practice-based commissioning – individual budgets. Potentially this is even more radical in terms of shaping future choices and services – and very many people with mental health needs use social care services. There are some important issues to be addressed here about the interface between this very individualised commissioning of social care services and the wider practice-based commissioning (PBC) regime for health services.

The aims of system reform can be summarised as:

- high-quality, personalised care
- greater patient choice
- faster, more effective and value for money treatment
- care closer to home
- more local control of services.

I expect these will be familiar to you, and perhaps, if anything, choice and value for money are the two perhaps most salient drivers, but it does raise all sorts of questions I think specifically for mental health services. For example, what are the implications of there being no tariff for mental health within the payment by results system? In terms of PBC, will individual practices or localities want to take on mental health commissioning? And given that the majority of mental health work is done in primary care anyway, who actually commissions that? And will PBC lead to a more fragmented micro divided approach? Commissioning a patient-led NHS raises a set of wider, 'bigger picture' issues. It could be argued that PCTs free of a direct providing role and

larger PCTs will have a stronger capacity to commission mental health. They will take more interest in it and will be better able to address some of the issues, for example around specialists commissioning. However, the reconfiguration also has raised worries about reducing co-terminosity, making it more difficult to plan jointly with local authority partners.

The notion of contestability as applied to mental health services is not unproblematic. Where are the new providers going to come from? Will it involve stimulating and helping existing voluntary sector providers to develop and to grow? Or are we talking about new models of social entrepreneurs like some of our colleagues in Surrey? Is there a danger that some of the whizzy new stuff around psychological therapies will attract the cherry-picking attentions of 'new kids on the block'? What will contestability mean in practice in terms of mental health services?

And finally there are big questions about choice. What does choice mean in the context of people with mental health needs? Is it simply about speedier access? Is it simply about choice of provider? And maybe there are more analogies in policy terms with the long-term conditions agenda than there are with the short-term, elective surgery agenda that is driving a lot of the development of choice within the NHS.

In terms of how we respond to all of this from a commissioning perspective, I am quite sure that one implication is the need for organisations to move away from what we have described in some of our work as a 'standard' commissioning cycle (straight-forward contracting and procurement) towards a much more strategic model that is pan-organisational, whole systems, that anticipates some of the potential consequences of system reform, of payment by results and practice-based commissioning in particular. Because if that works, then to put it bluntly, some providers and some services will no longer be required. Some people will choose not to use certain services. Some services will not be viable. So we will have to be just as good at decommissioning and disinvestment as we are at for commissioning for growth, which is what we've been used to the last few years. We will need to be very skilful in taking money out of unpopular services, failing services, unviable services, without the political roof falling in locally. We will need to be more adept in anticipating changes in people's preferences and redesigning services to meet them.

I've summarised below some of the main issues for commissioners of mental health services arising from this very wide-ranging complex set of challenges.



### Issues

- Personalisation
- Choice
- Access
- Delivering race equality
- Integration & partnerships
- Voluntary & community sectors
- Early intervention
- Prevention & well-being
- Psychological therapies

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A word of warning to those around these mantras of *access, choice and personalisation* – we mustn't think that this simply means how we get middle class people into hospital quicker for their elective surgery. 'Choice' is just as important for people with mental health problems as it is for any other section of the population. But I think we need to almost reinvent what those concepts mean in the context of mental health. And a strong feature of that must be maintaining the impetus on *delivering race equality*, and responding to the particular needs of diverse communities, and culturally competent care where we still have so much more to do. On the *Integration & partnerships* front there are particular opportunities here that arise from the creation within local councils of new posts of Director of Adult Social Care. Without the competing demands of children's services these ought to permit a stronger focus on mental health; and the posts, as they are being configured around the country, are increasingly about a wider well-being agenda and links to other government services. This should help mental health colleagues to join up public mental health with some of that wider local government well-being work.

The *Voluntary & community sectors* I've touched upon in the context of contestability – there is potential here to make better use of the entrepreneurial adrenaline that exists in large quantities in this sector.

There is a lot of work being done on commissioning – within CSIP and beyond – and I summarise below some useful resources to help you.



## Resources

### **System reform:**


[www.dh.gov.uk/PolicyandGuidance/OrganisationPolicy/Modernisation/SystemReform/fs/en](http://www.dh.gov.uk/PolicyandGuidance/OrganisationPolicy/Modernisation/SystemReform/fs/en)

### **Commissioning:**

Better Commissioning Network - [www.changeagentteam.org.uk](http://www.changeagentteam.org.uk)  
[www.networks.nhs.org.uk](http://www.networks.nhs.org.uk)

### **General**

[www.csip.org.uk](http://www.csip.org.uk) (including links to NIMHE)

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In summary, and at the risk of stating the obvious, the challenge for all commissioners is securing the right services in the right place at the right time and ... within financial balance. That's a tall order, a really tough one. But let me leave you with one statistic – 75%. This was the percentage of patients using mental health services who rated their care as good, very good or excellent in the Healthcare Commission's latest survey. That is a very impressive figure. It's so easy isn't it to beat ourselves around the head about all the things that are wrong about commissioning and providing and so on. But everybody that has anything to do with mental health services can take a real pride in that figure.

So on that positive note I will conclude there. And I wish you well with the rest of the day. I hope this has helped set the scene for you. Thank you.

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