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Editorials

Commissioning mental health services

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> There are bad times just around the corner,
> There are dark clouds travelling through the sky
> And it's no good whining
> About a silver lining
> For we know from experience that they won't roll by.
>
> **Noel Coward**[1]

In the summer of 2005 a letter from the Chief Executive of the NHS called *Commissioning a Patient-led NHS*, laid the framework for changes to primary care trusts (PCTs) and their provider role.[2] In summary, the letter described the process for PCTs to become solely commissioners of services, and that they would no longer be providers of healthcare. Linked to this clear and discrete function of PCTs would be the associated role of supporting practices and localities to take forward practice-based commissioning (PBC).

A number of articles in this issue relates to a conference organised by The Sainsbury Centre for Mental Health in November 2005, to consider how these changes would affect the way that mental health services are provided. The articles cover 'payment by results', commissioning structures, commissioning for change, commissioning in partnership with local authorities, and PBC. Together they provide a view as to how effective mental health commissioning is at present, and how it may change over the next two or so years.

However, although the articles are, and the conference itself was, able to describe the current state of play, and the current pressures, there was little about 'horizon gazing' – what is likely to develop beyond the next NHS reorganisation. An area that is very unclear, is how PBC will manage in those clinical areas for which there is no national tariff: e.g. mental health services, the criminal justice system, and the care services such as community older peoples' care, people with learning and physical disability etc. Therefore in the spirit of 'blue sky thinking' here are some potential examples of where PBC could usefully commission care services. For many of the examples, there is an assumption that the practice or locality is able to combine an individual budget from healthcare, with an individual budget from social services; this is s.31 of the Health and Social Care Act, and has always been used for the joint provision of (relatively) large populations of people. There is apparently no reason why it cannot be used for individuals, providing that the combined health and social care elements are used to provide care for the individual, not that the individual is given the combined amount to purchase care themselves.

(a) One solution is to limit PBC of care services to those individuals with complex needs, that cross physical health and social care needs. It is already possible to identify tariffs for most physical health disorders, and it should be possible to combine these with an individual allocation from social care, so that a single amount is available for a tailored health and social care package. This links closely with the commissioning of older people's services (see (e) below).

(b) Somatisation disorder: the evidence base around somatisation disorder is well developed; up to 50% of people attending acute outpatient services have medically unexplained symptoms, there are good evidence-based interventions for people who somatise, and there are ways to identify people who somatise. If people with somatisation disorder were diverted from acute outpatient departments to receive talking therapy instead, funded by the tariff costs that would have been spent on the acute referral, significant health gains would be achieved.

(c) What would happen if the mental health commissioning budget was managed by the local authority commissioners instead of health? It would certainly allow some of the outcomes that are around social inclusion (such as employment and accommodation) to be more closely aligned, and allow greater financial flexibility both in investing in services, and accruing the benefits of that investment. Currently a PCT is unwilling to invest in services that may accrue significant savings in employment or accommodation, as it does not deliver any savings within the PCT baseline. The difficulty in identifying a national tariff for mental health services, as well as the

supporting IT infrastructure remains a significant barrier.

(d) There is a similar case to be made for specialist learning disability services to be commissioned entirely by the local authority. The reasons are different, even though the endpoint may be the same as for mental health services. Specialist learning disability services are complex, led by local authorities, and PCTs have little or no experience in commissioning the service as, to quote the National Director, 'they are often led by the nose' by the private providers. Whether a local authority with all the resource, could do a better job remains a difficult question.

(e) Children and adolescent mental health services provide a different opportunity for shared budgeting – in that there are presumably resources from Department for Education and Skills (DfES), as well local authority, and health that could be combined to resource new ways of providing care. It is certainly true that the provision of Tier 1 services (services available in a primary care setting) are considerably under-resourced.

(f) Older people's services are a good example of where joint commissioning between local authority and health, can intervene effectively. The majority of the 'frequent flyers' are either older people or children, and so far as older people are concerned, the introduction of community matrons was intended to meet their needs, by providing flexible proactive care. PBC from a joint health and social care budget for each individual, would be an effective way of making the most of the opportunities offered by community matrons. Care must be taken to distinguish between the old pattern of case management, where managers purchased care packages for individuals on their behalf, and care management where individual (frequently highly experienced) professionals were responsible for delivering a flexible care package to a client/patient. The community matron clearly falls into the latter care management category, and there has been extensive work undertaken to plan intermediate care programmes of care. PBC for care services just develops those programmes even further.

(g) There is an opportunity to align the new General Medical Services (nGMS) Quality and Outcome Framework (QOF) for people with severe mental illness, and PBC. The amended QOF for severe mental illness will require that there is an electronic list of such individuals, and that primary care's responsibility is to ensure that their care is co-ordinated. Such individuals have needs that are based in mental health (no tariff as yet), physical healthcare (significant needs are evidenced based) and social care. If PBC was able to commission an individual care package for those on the electronic list, by combining at least the physical healthcare tariffs and the social care individual allocation (indicative or otherwise), there would be a real opportunity to reconfigure care pathways to better meet the needs of the people.

(h) People with long-term conditions: conditions such as diabetes, asthma and ischaemic heart disease are long-term problems, for which the condition also has social care implications. If a patient with diabetes has vision problems (a not uncommon complication) then there will be social care needs that are part of the overall care that is needed, but which would not be included within the tariff for diabetes care. Providing a combined resource to manage all the conditions of the patient – both their physical and social care needs – provides an opportunity to ensure an holistic approach to care, and one that from the patient's perspective is 'joined up'.

(i) Can a prison population be described as a 'practice list'? If it could, then the practitioners could commission services in the same way that any other practice could do so. The reason that this is important is that the healthcare needs of a prison population are quite different from those of the 'average' population, and it is difficult to meet their needs from the use of standard NHS care pathways. A literature review on the needs of those recently released from prison, is available at the Sainsbury Centre for Mental Health website, which describes the issues with great clarity.[3]

It would appear that PBC could provide something different, that would really benefit those who are most vulnerable.

The issue, of course, is whether that is likely to happen, or will the NHS reforms just increase the bureaucracy, as general practitioner (GP) fundholding did, rather than really delivering improved health outcomes? Experience from previous reforms suggest that the 'dark clouds won't roll by', and that the silver lining is just an illusion. To really deliver improved health outcomes for the most vulnerable in society, PBC will need strong leadership, and a strong vision for the future of healthcare. Who should provide this?

REFERENCES

1 Knowles E (ed). *The Oxford Dictionary of Quotations*. Oxford: Oxford University Press, 2004. Available on Oxford Reference Online www.oxfordreference.com (accessed 18 January 2006).

2 Department of Health. *Commissioning a Patient-led NHS*. London: Department of Health, 2005.

3 Sainsbury Centre for Mental Health. www.scmh.org.uk (accessed 20 January 2006).