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Research papers

Health policy in England and Wales is changing fast and is likely to have wide ranging effects on how primary care mental health is delivered. To keep abreast of these changes for readers in England and Wales we have joined forces with the Sainsbury Centre for Mental Health (SCMH) formally from Volume 3 of *Primary Care Mental Health*. The Director of Primary Care at SCMH, Dr Alan Cohen will become co-editor of the Journal to reflect this changing world for everyday primary care practitioners. We will have themed issues in the future and Readers are encouraged to suggest themes they would like to be addressed. We will also be enlarging our editorial board. The peer reviewed research papers will still be a large part of the Journal and will continue to be edited by myself. Two recent papers on relevant issues are reproduced in this issue for the interest of our readers who may be wondering if practice based commissioning is simply a return to 'fundholding' and on the area of payment by results rather than by capitation etc.

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Practice based commissioning in the NHS: the implications for mental health

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SUMMARY

The Government recently set out new plans for general practitioners (GPs) to commission a range of specialist health services for their patients. The plans, called practice based commissioning, allow for budgets to be devolved from primary care trusts (PCTs) to individual practices.

The scope of practice based commissioning includes most mental health services. The Sainsbury Centre for Mental Heath (SCMH) is concerned that this may be premature. There is a risk that the payments system for mental health care (which will soon be different to many other NHS services) will put cost above quality and patient choice in making decisions about what to commission.

While there are important benefits to the new system, SCMH recommends that practice based commissioning is not extended to mental health services until it can be done on an equal basis with other parts of the NHS.

Keywords: to come?

Background

After its election victory in 1997, the Labour Government implemented major changes in the NHS. These changes included the abolition of GP Fundholding – a scheme that gave general medical practices actual budgets to commission services on behalf of their patients – in favour of setting up primary care groups (later primary care trusts, or PCTs) which would commission services collectively for the local population.

In 1998, the year that fundholding was abolished, the Government made clear in *The New NHS* its desire to see practices offered indicative

budgets to commission a full range of services.[1] In *The NHS Improvement Plan* it stated that practices would be able to have an indicative budget from April 2005 to commission, if they wished, a full range of services.[2] The guidance on practice based commissioning published by the Department of Health in October 2004 provides the detail of what the scheme will allow practices and PCTs to do.[3]

There have been other major changes to the NHS since 1997, but they have all been directed at providing a high quality service whilst giving the user of the service a choice as to what is appropriate for their own needs. One of the major stumbling blocks to introducing choice was learnt from the GP fundholding scheme. Different providers could offer the same service for different costs; thus a hip replacement or a cataract operation in London might cost more than the same operation in the North West. A patient might therefore be referred to the one hospital where the contract for that surgery was placed, or the hospital where the service was cheapest, rather than being offered a choice of which provider had, for example, the shortest waiting list, or was most convenient for the patient. Information as to the outcome of that type of surgery, or other aspects of the process was unavailable. The consequence was that patients had no choice, and that services were variable throughout the country – the so called 'postcode' health service. Users of the service had no way of knowing the quality of the service delivered, nor a choice of where to go for that service.

These problems have been addressed by the Government, by ensuring first that the quality of services improved, second that cost was not an issue in choice, and third that the information was available so that an informed choice could be made.

Quality

Quality of care was ensured through the introduction of National Service Frameworks (NSFs) to ensure that services were of a uniformly high standard. In addition, the National Institute for Clinical Excellence (NICE) publishes guidance on managing clinical conditions, based on the latest research, as well as describing when new interventions should be made available to the NHS. Their guidance on different conditions can be found on their website at www.nice.org.uk. The Commission for Health Improvement (CHI), and later the Healthcare Commission, visited NHS trusts to ensure adherence to the frameworks and clinical guidelines. The results can be found on their website at www.healthcarecommission.org.uk.

Cost

The cost of the service has been addressed more recently by the introduction of a scheme called Payment by Results. In this system a procedure or spell of treatment has a national tariff or cost. This tariff is applied equally throughout the country so that a dermatology outpatient spell of care will cost £240 in both London and in the North West. The intention is that cost should not figure in the process of the user of the service choosing where they go or what service they feel to be most appropriate for their own circumstances.

Information

Accurate information is required to support this major redesign of the underlying principles of the NHS. The Government has invested heavily in a national system called NPfIT – The National Programme for Information Technology, which will deliver the systems, and hence the information, to allow these developments to be implemented successfully.

Practice based commissioning has thus been introduced, not as a whim, but as part of a continuing long term strategy to give users of the NHS the ability to chose where and how they get a high quality, up-to-date service anywhere in the country.

The implications for mental health

The Guidance on practice based commissioning makes clear that all services can be commissioned by a practice except those identified in Guidance on Commissioning Arrangements for Specialised Services.[4] This guidance lists services that should be commissioned by consortia of PCTs, as they are highly complex, low volume and frequently high cost services. They are usually termed 'tertiary services', as patients are referred to these specialist services by secondary care clinicians – for example by community mental health teams rather than by their GP.

A full list of tertiary mental health services is in Box 1.

All other services are considered to be secondary care services and are capable of being commissioned by practices with their indicative budgets. This will include community mental health teams, psychological therapies, other talking therapies,

Box 1 Tertiary mental health services

- Tertiary eating disorder services
- Neuropsychiatry
- Forensic mental health services
- Specialised mental health services for deaf people
- Specialised addiction services
- Specialist psychological therapies for inpatients and specialist outpatient services
- Gender identity services
- Perinatal psychiatry services (mother and baby units)
- Complex and/or treatment resistant services
- Asperger's syndrome

and the more specialised community teams such as assertive outreach and early intervention.

The implementation of choice is dependent on the provision of a consistent, high quality service; on cost not being an issue; and on the user having the information to make an informed choice. Each of these three principles must be present in mental health services to allow practice based commissioning to be undertaken successfully.

Quality

The first published NSF was in Mental Health, and it has without doubt gone a long way to improving the quality of the service, and ensuring a consistently high level of care.[5] This is not the place to assess whether or not these aspirations have been successfully implemented, and since the ten-year plan of the NSF is only half way through, such an assessment might be considered premature. NICE has published a number of documents on mental health, including guidelines on the management of schizophrenia, depression, and anxiety, while CHI (and its successors) have reviewed all mental health trusts and most PCTs. There will always be the opportunity, and desire, to improve the service, but without doubt there has been progress over the last five years.

Cost

The same cannot be said of the second principle – that of ensuring that cost is not an issue in patient choice. Payment by Results sets a national tariff for spells of care. When that spell of care is clearly defined by diagnosis, need, duration and intervention, allocating a cost is (relatively) straightforward. There can be an agreement between different trusts that they are comparing like with like. A hip replacement in London is likely to be very similar in diagnosis, need, duration and intervention required, to one in Dorset. However, the introduction of Payment by Results in April 2005 excludes mental health services as it has not yet been possible to allocate national tariffs to care provided by mental health trusts.

This is not a great surprise. The SCMH interim report, 'NHS Foundation Trusts and Mental Health' argued that a commissioning model for acute episodes of care such as elective surgery may not be the best method for commissioning a comprehensive mental health service.[6] The Department of Health has been unable as yet to identify the Health Related Groups (HRGs) or Diagnosis Related Groups (DRGs) on which a national tariff in mental health is based. Without doubt this is in part because assessing the case mix of the workloads of CMHTs and other specialist teams is extremely difficult.

Evidence from elsewhere in the world supports the complexity of the problem. In the United States, mental health inpatient care is excluded from the Medicare programme, and a payment for inpatient days is made on a daily rate, rather than implementing a national tariff as is done in other clinical areas. In New Zealand, where case mix was assessed, it was found impossible to implement a national tariff that accurately reflected patient need. A similar difficulty was found in Australia. A more detailed analysis of Payment by Results in mental health is shortly to be published by SCMH.

With no national tariff for mental health spells of care, practices will find commissioning mental health services extremely difficult. The situation as proposed is little different to the fundholding scheme of the 1990s, when practices could commission talking therapies from mental health services. The result then was a shift in emphasis away from those with a severe and enduring mental illness towards providing services for those with a common mental health problem.

This shift was seen by many in the mental health field as a retrograde step that set up a fragmented,

multi-tiered service. Nothing in the current guidance will prevent this from happening again. In the fundholding era, practices could not commission services from CMHTs. With the current guidance on practice based commissioning there is the opportunity to commission all secondary care from a mental health trust. This could significantly fragment services, and put an untenable strain on primary/secondary care relationships.

Information

The information infrastructure to support practice based commissioning of mental health services is not in place. Despite the enormous resource being invested in NPfIT, the programme for mental health trusts is lagging well behind that for acute trusts. The information that is required for a practice to commission services and to be able to offer users a meaningful choice is not in place.

We recommend that secondary mental health services are excluded from practice based commissioning until Payment by Results and the information infrastructure is in place to support effective commissioning.

Managing practice based commissioning

Several broader issues in the guidance on practice based commissioning are worthy of further debate.

Service user and carer involvement

Currently, within each PCT a mental health local implementation team (LIT) advises on commissioning. In some cases the LIT undertakes the commissioning itself. The LIT has a membership that covers all major stakeholders, and in particular service user and carer groups. It is not clear from the guidance that a practice considering the commissioning of mental health services would have to involve other stakeholders in making proposed changes, nor how users and carers would be involved. Considering the advances made in this area by PCTs and mental health trusts, for practices to exclude this group from potential changes seems illogical.

We recommend that further consideration is given as to how other stakeholders can be more effectively involved in the commissioning intentions of practices.

Giving notice of changes

When PCTs wish to make a significant change to their commissioning intentions, they currently have to offer the provider trust six months' notification, and to consult publicly on their intentions. In the Guidance, neither seems to be obligatory. The Guidance allows the practice to make changes as it sees fit, with little or no warning to the provider trust.

We recommend that any change in commissioning policy by practices is signalled in advance to providers, so that the impact of these changes on other services can be fully explored.

Financial risks to PCTs

Despite the budget allocated to practices being indicative, it is clear that up to 50% of any savings generated by the practice are retained by the practice. However any losses generated by the practice are managed by the PCT, and only after three years can the PCT review the right of practices to commission services. The financial risk that this poses to PCTs, which may already have a financial deficit, is significant.

Legal constraints

There are a number of legal issues that complicate practice based commissioning of CMHTs. If a practice commissions from a private service, or from a mental health provider that lies outside the local authority in which the practice patient resides, there may be considerable difficulties if a patient should require social services support, or require assessment and compulsory admission. Such a situation is common in London, where there are several possible providers, and patients often live outside the Borough in which the practice is located.

The local authority Approved Social Worker may be faced with an assessment of a disturbed patient who is outside their local authority area (and hence will have no jurisdiction). There may also be difficulties if the patient is in a private hospital and if joint working is either limited or non existent.

The benefits of practice based commissioning

While the commissioning of all secondary mental health services may be premature, there are without doubt some real opportunities that present themselves around limited commissioning of some services.

Evidence to be presented in NICE guidelines on depression and on anxiety will demonstrate the value of cognitive behaviour therapy (CBT) in primary care. The opportunity to commission such services would be a welcome way of providing them services, where previously they may not have existed. Waiting times for 'talking' therapies remain long in many places, presenting a major barrier to patient choice in mental health care.

Evidence on effective interventions for people with somatisation disorder, who present frequently to acute trusts and attend outpatient departments with complaints for which no physical cause can be found, can be successfully managed with therapies such as re-attribution training and CBT. The advent of Payment by Results does present an opportunity to save on acute outpatient referrals and to invest in CBT to provide these patients with a more effective treatment option than recurrent referrals and investigations that do not demonstrate any underlying physical illness.

To prevent practices from innovating in this area would be as inappropriate as allowing practices to commission early intervention or assertive outreach teams.

We recommend that practices are encouraged to commission evidence based talking therapies, and to innovate in treatment options for people who have somatisation disorder, as well as common mental health problems.

Conclusion

The introduction of practice based commissioning of all mental health services ispremature. This is because:

- There is no national tariff for mental health spells of treatment.
- There is no IT infrastructure to support practice based commissioning.
- There is insufficient guidance on the role of the LIT, stakeholders, users and carers in commissioning mental health services.
- There are legal consequences of commissioning services without the local authority.

Practice based commissioning of mental health services should be delayed until these issues can be addressed. But there should be the freedom for practices to commission evidence based talking therapies for some people with common mental health problems.

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