

GP consortia and community mental health services – a new model

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The 2010 Department of Health White Paper *Equity and Excellence: Liberating the NHS*¹ outlines plans to place commissioning in the hands of new GP consortia, thus breaking down the primary/secondary care divide. In this article, Dr Hashmi and Professor Mortimer discuss what they think the changes will mean for community mental health services.

The liberation of the NHS in terms of a social enterprise model could be a step in the right direction. Over the years, the NHS has become a highly bureaucratic, irregularly systematised, over-inclusive organisation, with gradually falling productivity. Despite more than three decades of iterative ‘reorganisation’, a further overhaul is almost certainly required to ensure the future survival and financial viability of the NHS. This article is focused on the position of mental health services in the new world of social enterprise; a concept that, hopefully, represents another way of looking forward to a better future.

Primary and secondary care divide

The arbitration of primary and secondary care has generated multiple unnecessary management thresholds, with complex systems of service delivery, which include waiting lists, shortfalls and rationing. This is an uneconomical way to transform cash into care. Irrespective of the size of future GP consortia, elements of secondary care may be incorporated into primary care through the new model. We have used community mental health services as one example, but the model applies to any medical care that does not require the enhanced care afforded by specialist inpatient services.

The existing model of community mental health services

At present, community mental health services are a part of secondary care, subdivided into various teams. These include the generic community mental health team, the assertive outreach team, early psychosis services and crisis resolution and the home treatment team. Teams are led clinically by a consultant psychiatrist and managed by a senior nurse or a social worker, with varying numbers of team members depending on the size of the population of a defined sector and the levels of mental health morbidity. The size and capacity of the team is invariably proportional to the available resources.

The strengths of generic community mental health teams are well established. According to the joint report published by Aston University, the University of Glasgow and the University of Leeds in 1999 on the effectiveness of teams in the NHS, ‘the best and most cost-effective outcomes for patients and clients are achieved when professionals work together, learn together, engage in clinical audit of outcomes together, and generate innovation to ensure progress in practice and service’.²

Community mental health team management was also shown to be superior compared to non-team-based standard approaches

using meta-analysis,³ and superior in promoting greater acceptance of treatment.⁴ However, generic community mental health teams have faced criticism of role limitations due to the development of specialist mental health teams. Irrespective of their strengths and weaknesses, it remains essential to implement the operational strategy of community mental health teams in accordance with the NHS Operating Framework Plan 2010-2015, as outlined in the 2010 White Paper.¹

The proposed model of community mental health services

The principal proposed strategic NHS change is to establish GP consortia, with the potential to employ specialists for GP patients by phasing out the primary and secondary care divide where possible. This model envisages the future GP consortia to be able to employ consultant psychiatrists, with the opportunity to develop their own community mental health teams to cater for the specific needs of their patients, with tailor-made individualised care plans paid for by personalised budgets and social care package entitlements.

This model would not only abolish the plethora of multiple teams, but would also focus on the enhancement of inbuilt specialism within a team to deal with a range of mental health issues, thus min-

imising the risk of overinclusive bureaucracy and communication failure within the multiple teams structure. This is in line with the Royal College of Psychiatrists' occasional paper on the future development of UK mental health services, recommending 'enlarged community mental health teams' with a range of in-built specialisms. Furthermore, 'consultants should be used in complex assessments and management, rapid reviews of those in crisis and advice to multidisciplinary teams and staff working in primary care'.⁵

The primary function of the team is to remain the same: to provide community mental health support to patients with serious and enduring mental health needs. Existing shared care protocols for mental disorders can be utilised in the consortium within a more productive working environment. The role of the consultant would also stay the same: to confirm diagnosis, prescribe medication and hold overall responsibility for the treatment plan. This model is financially viable due to less bureaucracy, fewer managerial overheads, pragmatic overlapping of service and reliance on one robust community mental health team instead of multiple teams, which often (more or less) undertake similar work despite the ideology behind each team being distinguishable.

This model should enhance mutual learning: while operating from the bases identified at GP practices, for instance, practice nurses could be trained by community psychiatric nurses to institute and monitor treatment of mental disorders such as long-acting depot medication for patients with chronic mental illness. This would enable community psychiatric nurses to extend the scope of their psychotherapeutic interventions and have more time to spend

with patients with enduring mental illnesses and their families

The other benefit would derive from abolishing the 'Care Cluster Model' of payment by results (PbR). The Care Cluster Model was designed to horoscope mental health patients into 21 separate categories ranging from simple anxiety or depression to florid psychosis or severe depression. Each cluster carries a weighting, which is translated into the amount expected to be spent providing care by secondary services. By this method, secondary care planned to charge primary care for providing care to patients.

The advantage of the system is more financial than clinical, and patients who cannot be 'clustered' or fall below the criteria are deemed not to receive a service from secondary care, because secondary care cannot bill primary care for treating them. The suggestion here encourages care provision for everyone who needs the service, irrespective of the level of symptoms or funding, because there will be no primary and secondary care divide. In addition, patients will appreciate continuity of care from the same mental health team throughout their engagement with the services. The present system lacks this facility.

Interface with psychiatric inpatient care

Most secondary mental health services have replaced a substantial proportion of their inpatient beds with community alternatives, particularly crisis and intensive home treatment services. There will always be a requirement, however, for inpatient beds, in addition to those now provided as social care placements. Indeed, there has been something of an explosion in private sector care provision for the mentally ill, with many facilities offering secure, semi-secure or rehabilitative care. The

arrangements for securing and maintaining such care are recon-dite, lengthy and presumably expensive in the extreme in our experience, as they involve so many interested parties with multiple budgets who not infrequently disagree with each other, never mind the treating team.

A drastic simplification whereby the GP consortium commissions the care of needy patients through the direct advice of their consultant psychiatrists could remove much delay and expense, and encourage quality value for money care on the part of private providers. Ordinary brief acute care episodes could continue to be provided in NHS secondary care: it is even possible that the enhanced community team could 'defunctionalise' and revert to seamless continuity of care for the minority of patients requiring relatively brief acute admission.

Development of medical adjudication

It is not unusual for consultants in subspecialties of psychiatry to have a difference of opinion regarding patient diagnosis or a future care plan. It may be that the difference of opinion is based on service provision issues: this may result in the referring consultant accepting the colleague's opinion irrespective of patient needs. This has the potential to result in patients receiving a compromised care package and retaining unmet needs.

For example, in respect of patients with mild learning disabilities and patients within transitional age groups, it is not uncommon for general psychiatric services to argue that training and resources are not available. Neither do these patients fulfil criteria to receive subspecialty services: they 'fall between two stools' and cannot access the services they need. There is no system

of medical adjudication that can look at the needs of these patients, and authorise an apposite care package. Removing the plethora of subspeciality teams may obviate this issue; alternatively, the new arrangements would lend themselves to such a system across the consortium establishment.

Potential risks

Every action has consequences and carries a risk, alongside the anxiety that comes from sailing in uncharted waters. This, however, has never discouraged change within the NHS. Change is often unpopular; moreover, any model is always a simplification of the real world – an increasingly complex and interconnected place.⁶

The NHS Plan 2010-2015 is expected to evolve and take shape within a specific time frame to achieve the planned objectives: this includes further financial review and major operational planning by April 2011. It is expected to develop shadow GP consortia soon after and progress quickly to achieve the final target of full implementation of a new NHS Board, an outcome framework and a fully functional new model NHS. Any delay at any stage of development carries an escalating risk of uncertainty, which inevitably generates insecurity, possibly leading to staff losing motivation or choosing not to appraise the change. Moreover, if the newly developed team is expected to undertake quality work with expansion of its role and responsibilities, it ought to be properly resourced. Despite the current financial pressures afflicting the NHS, unrealistic budget cuts would likely represent a false economy, manifest by mounting staff stress levels, an increase in sick leave, and very possibly an escalation of serious untoward incidents.

Key points

- The primary and secondary care divide is an uneconomical way to transform cash into care
- The new model envisages the future GP consortia to be able to employ consultant psychiatrists, with the opportunity to develop their own community mental health teams to cater for the specific needs of their patients
- This model would not only abolish the plethora of multiple teams, but would also focus on the enhancement of inbuilt specialism within a team to deal with a range of mental health issues
- The advantages of the Care Cluster Model are more financial than clinical
- Change is often unpopular; moreover, any model is always a simplification of the real world situation

There will be unexpected challenges and a likelihood of ‘teething problems’ as the model begins to interact with the real world. These issues may be difficult to foresee and anticipate.

Conclusion

In essence, the merging of speciality teams in community mental health and the dissolution of the primary/secondary care divide is viable, progressive and in line with the expected transformation of the health service in England. The extension and enhancement of the community mental health team is one of the future developments recommended by the Royal College of Psychiatrists. This model discourages multiple specialist teams’ separate operational structures, communication failures and unnecessary overheads.

The model highlights the benefits and opportunities for future service provision: it concedes associated risks that could affect progress directly due to limited resources, or indirectly because of delay or ‘watering down’ of implementation. Even so, the model remains patient focused and financially tangible with intrinsic integrity. The new approach, particularly if accompanied by investment within the mental health services, should be likely to succeed.

Declarations of interest

None.

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