BRIEFING 3

The aim of The Sainsbury Centre for Mental Health is to improve the quality of life for people with severe mental health problems by enabling the development of excellent mental health services which are valued by users, carers, and professionals. The Sainsbury Centre seeks to achieve this by influencing policy and practice through a co-ordinated programme of research & evaluation, communication and development.

An Executive Briefing on the Implications for Mental Health Services of the Consultation Paper *Partnership in Action*

What is the context?

Partnership in Action needs to be seen as part of the Government's desire

- to deliver integrated care across health and local authorities
- to get staff to address patients or clients as individuals with a range of needs, regardless of bureaucratic boundaries.

This approach has the potential to yield great benefits in mental health. *Partnership in Action* is therefore a significant document for everybody involved in mental health care. The direction of travel is very welcome, but because the issues are highly complex the detailed framework proposed for services will require careful consideration.

In order to achieve better joint working it will be important to address not only the legal and administrative framework, but also the many practical blocks to progress. While The Sainsbury Centre has argued for a more flexible legal framework, this in itself cannot deliver better joint working. Staff attitudes, training and culture, the extent of service development locally, and the level of resources available are equally important. Any development programme needs to address these wider issues, not just the legal and administrative framework discussed in the Consultation Paper.

Why is *Partnership in Action* important for mental health?

The aim of a good mental health service is to provide integrated and effective care to the user. However, research evidence, reports from inquiries, and service users' own experiences, show that mental health services are not always well coordinated across health and local authorities. Managers and practitioners also experience a variety of obstacles that can hinder effective joint working.

The new Consultation Paper puts forward a number of proposals for improving joint working between health and social services which offer important opportunities for mental health services to become more integrated and efficient. However, the document understandably does not detail

- precisely what changes will be made to the legal framework
- how the proposed flexibilities will actually work in practice
- what their implications are for professionals, managers and users.

This briefing attempts to unpack some of the issues to provide a basis for debate and discussion by Chairs and Members of Trusts and Authorities, senior managers and practitioners and other stakeholders. Although it is addressed to mental health services, many of the points raised are relevant to other client groups affected by the Consultation Paper.

What are the key reasons for change?

The health and social care divide has been debated for decades. It has never made much sense to users or carers, but there have been advantages in terms of sustaining different models of care and in delivering accountability to the local community. However, the split has become more obvious in recent decades with the development of more community-focused services. Radical change has been unattractive for political reasons and because of the potential upheaval and loss of focus on service improvement.

In recent years – as mental health services have shifted from a hospital care model to comprehensive local care – a number of blocks to joint working in mental health have been highlighted. These include:

- different culture, attitudes and mind sets. Diversity in models of mental health care is no bad thing. However, it is essential that practitioners understand each other's models and share an understanding of the core objectives;
- different statutory responsibilities, political accountability and priorities;
- different procedural systems. The differences between the Care Programme Approach in health and care management in social services have caused endless confusion and irritation;
- perverse incentives. The different agencies involved in mental health care have been subject to different financial incentives – the present system rewards agencies for moving clients out of their service into someone else's – not for constructing seamless and continuous care packages;
- lack of coterminosity;
- instability. Joint working sometimes relies on personalities or the prevailing local politics and can therefore be jeopardised by career moves or election results.

What are the models for joint working put forward in the Consultation Paper?

The Paper identifies three levels at which joint working must take place, and proposes a range of new mechanisms which can work at each level, to deliver greater integration. This document explains these in terms of mental health.

The levels are:

1. Strategic planning – which involves joint medium term planning and information sharing. This is of particular importance for mental health, because the service model is quite complex, requiring time to put in place and sustained coordination to implement.
2. Commissioning – the services which are commissioned year on year need to mesh together and build towards the joint vision. This needs to reflect the strategic plan, and in this sense levels 1 and 2 are not distinct.
3. Service provision – people with severe mental health problems have a particular need to receive integrated packages of care, meeting a range of health, social care and other needs.

The Government has proposed a number of mechanisms for enabling greater integration at these three levels.

The mechanisms are:

1. Pooled budgets. This would involve bringing together some or all health and social care monies into a single budget to purchase (or provide) care for a particular client group such as mentally ill people. Current legislation does not allow budgets to be pooled.
2. Lead commissioners. This would involve one of the key players locally taking on lead responsibility for commissioning some or all mental health (or other) services. This would be either the health authority, social services authority or a Primary Care Group/Trust (PCG/PCT). This cannot happen currently because of

the statutory responsibilities of the different agencies and their limited abilities to delegate to each other.

3 Integrated providers. A NHS Trust, Primary Care Trust or social services could take on the delivery of a wide range of mental health care across health and social care. Again, there are currently administrative and legal obstacles to this – including guidance about income generation by NHS Trusts – although some partially integrated providers do exist (e.g. Riverside NHS Trust). The document also advocates the introduction of 'one stop shops' – premises where users and carers receive both health and social care – to which there are currently no such obstacles.

What does this really mean?

The Consultation Document is ambiguous about the precise legal framework or how the flexibilities offered will work. In particular, it is not clear that what is happening at the *macro* level in terms of strategic commissioning, configuring services etc, has been linked to what happens at *micro* level where individual staff and teams purchase and provide services for clients. A clear framework is required at both levels if the benefits are to be maximised.

The case studies offered also suggest that Government might have unrealistic expectations about the level of increased efficiency which can be achieved through new legal flexibilities alone, although the aspiration to reduce barriers is clear and welcome. To deliver these aspirations increased investment and attention must be given to issues like human resources and organisational culture.

In practical terms the flexibilities, subject to the precise mechanisms envisaged, might allow:

at macro level (planning, commissioning and strategic management)

- a single authority/board and single Chief Executive to be responsible for commissioning services
- one strategic plan for all health and social care services – springing from and/or expressed in the Health Improvement Programme

at micro level

- community teams to have the same employer and manager
- the Care Programme Approach and care management to be fully integrated
- users or carers to have either a single agency (PCT) or one commissioner and one provider to deal with.

What are the possible models for mental health?

There are a number of possible models for mental health which could be used to push forward the joint working agenda, for example:

1 Primary Care Trusts could be allowed to commission a wide range of mental health services and provide community and primary care, including some social care. They would have to commission acute psychiatric care elsewhere, because of critical mass, and also to create incentives to develop community services and minimise the use of inpatient beds. This development might require a step back on the part of Government from its position favouring stand-alone mental health Trusts set out in the White Paper. However, this depends where you draw the line between specialist and general mental health services.

2 Health Authorities/PCGs could commission all mental health services (as lead commissioners) using a range of providers.

3 Social Services Authorities could commission all mental health services using a range of providers – presumably this model would require transfer of HA staff on secondment.

4 Joint commissioning using current models could continue but using a pooled budget. In this case a jointly agreed mechanism will be required to manage the budget which could take the form envisaged in The Sainsbury Centre publication *Pathways to Partnership* (1). The pooled budget could be applied at a variety of levels within the system.

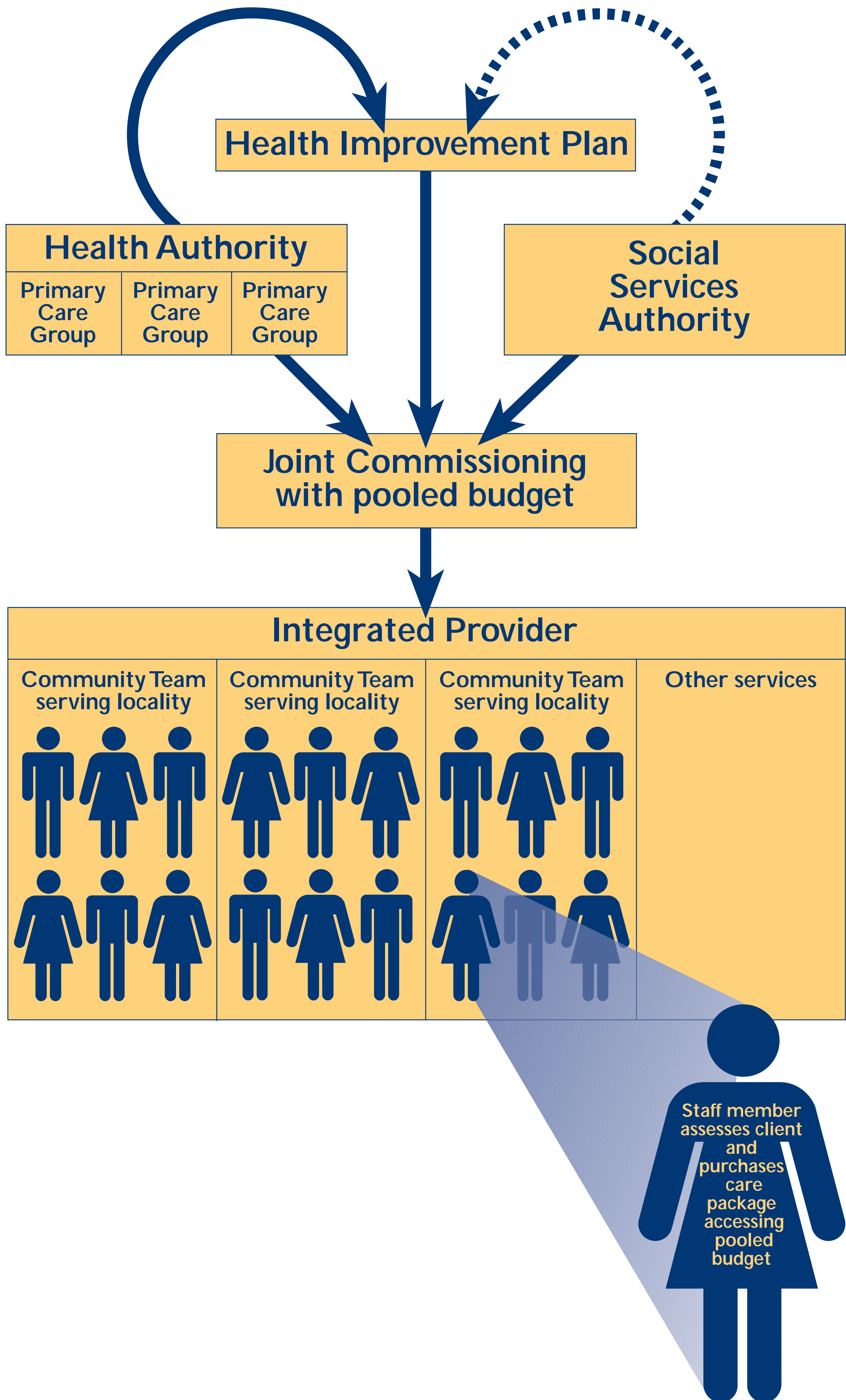
5 A single mental health provider – probably a NHS Trust – could deliver a range of services across health and social care.

And there are a number of variations in between. At micro level this could mean that individual practitioners such as community mental health nurses or social workers could use care management to purchase an integrated package of social care and health care for a client. This is in many ways an attractive model which is already being developed in the field both in mental health and for other client groups. One possible variant of this model is illustrated overleaf.

What are the opportunities?

There are strong arguments for developing such models in mental health. They could deliver or support:

- joint working seen as a core – and wide ranging – activity for senior management
- clear and visible leadership
- a single plan effectively as a subset of the Health Improvement Programme
- pooling of effort and resources – this is particularly vital in commissioning where expertise is spread very thin
- integrated mental health provision
- single practice guidelines including merging of the CPA and care management
- a single set of national priorities with integrated performance management – this is already in hand


Health Improvement Plan
Health Authority
Primary Care Group
Primary Care Group
Primary Care Group
Social Services Authority
Joint Commissioning with pooled budget
Integrated Provider
Community Team serving locality
Community Team serving locality
Community Team serving locality
Other services
Staff member assesses client and purchases care package accessing pooled budget

- stronger integration of primary health and social care
- a single human resource strategy with shared training
- sensible organisation across localities
- stronger accountability.

The most important opportunity must be the possibility of providing integrated, well-tailored care packages, resulting in better outcomes for users and carers. Conversely, if this cannot be delivered there is little point in organisational change. Many services are already delivering a high degree of integration within the existing framework. This progress must be built on.

What are the threats?

There is a danger that radical and exciting proposals such as these could cause managers and practitioners at all levels to take their eyes off the ball. The aim is to provide comprehensive services which meet users' needs – not to continue the cycle of reorganisation which has continued for decades. The idea that there is one last reorganisation which can deliver truly integrated care is a dangerous illusion. There will always be some boundaries – although some create more perverse incentives than others.

The possible threats and challenges arising from these proposals include:

- some new boundaries might be created which are unhelpful to integrated care. Depending on how the model is used boundaries could be created, for example, between acute and community services or between children's and adult's mental health services;
- overload is a major issue for staff at all levels. The change agenda is now so big that any change – even one which attracts widespread support – could lead to burn out and demoralisation. This is a serious risk;
- defining the scope of the pooled budget may be difficult. There will be few incentives for authorities or agencies which are passing over lead responsibility for mental health to transfer more than the minimum. Equally little is said about the extent of delegation which will be allowed between agencies at present – this needs to be carefully considered;
- planning blight could be an issue, especially if local authorities perceive the NHS is wishing to 'take over' mental health. There will be few incentives for authorities in this position to put major management effort into mental health unless they are engaged in strong partnerships and will have a continuing voice;
- users may not welcome the creation of what they see as large monolithic providers. Many users prefer a diversity of models and of providers;
- the challenge of joint working with other key agencies such as housing authorities and employers remains, although a clear lead within health and social care may help in this respect;
- in areas where health and local authorities are not coterminous it may be more difficult to negotiate the best use of new flexibilities. However, there is also an opportunity here to solve problems created by different geographical boundaries – especially using the single provider model;
- because none of the proposals are intended to be mandatory some areas may move faster than others. Progressive areas will benefit from the new flexibilities but areas with poor joint working will not be given new impetus. This could lead to a two tier or even multi-tier system where some parts of the country have well integrated services, while others have poor joint working;
- charging will raise a number of difficulties which have not yet been addressed. Service users may have genuine concerns about which services will be charged for, and this may create practical and presentational problems;
- it is unclear what mechanisms will replace JCCs to ensure coordination and consultation. While JCCs have not always been a great success strong mechanisms are required to ensure consultation with the community and with users. It is unclear that HImps will deliver these although they have the potential to do so.

What can be done to maximise the opportunities?

Despite these more problematic areas, the Consultation Paper undoubtedly offers some major opportunities for mental health. In particular, areas which are already testing the statutory framework to its limits in order to achieve integrated care, may be able to move forward quickly.

To gain maximum advantage from the new flexibilities, key stakeholders will need to:

- determine which particular flexibilities are of use locally, to meet locally defined objectives. Some models may be more suitable for some areas than others. For example, a single agency approach based around PCTs is arguably well suited to areas of urban deprivation where primary care is poorly developed. Many of the flexibilities will be relevant to Health Action Zones and some have already been requested in HAZ proposals;
- build on existing good practice. There are various successful examples of joint working around the country, with further projects under development. The Sainsbury Centre will assemble a database of such projects to form part of a wider *Mental Health On-Line* service;
- address the staffing implications and opportunities. Staff will need to be trained to work using the new practices and procedures required. This will require shared training across agencies and disciplines. Again, there is much in the way of good practice to build on;
- set clear objectives and timetables for change which support rather than prejudice service development;

- performance manage the process to help poor performers move towards the standards of the best. Government and Regional Offices of the NHS and SSI have a key role to play here. The prospect of greater coordination at this level is very welcome;
- involve local people and users in drawing up the single strategy and on an ongoing basis. There are now a number of useful methodologies emerging to encourage local participation;
- the information technology issues in terms of providing a single information system across health and social care, and commissioners and providers, are formidable and will require strong national leadership if they are to be solved.

What are the key questions to be resolved and how?

The Sainsbury Centre, in discussion with its legal adviser, has identified six key questions arising from the Consultation Document, which will need to be resolved as the NHS, local authorities and other partner agencies move forward:

1 *What is the status of HImPs (=Health Improvement Programmes) and JIPs (=Joint Investment Plans)?*

HImPs are central to the Government's proposals as they are to contain the agreed joint strategies. They provide

- the link between the public health agenda and service development and configuration issues
- the vehicle for defining a jointly agreed way forward between health and local authorities.

However, there is little information or direction as yet on

(i) how they will reflect local community and consumer views

(ii) how the local authority perspective will be given strong and continuing weight, or how local councillors will be informed about and engaged with the process.

The very name 'Health' Improvement Programme is perhaps unhelpful in this context. One way forward would be to place a statutory duty on health authorities to consult on and publish their HimP. Arguably these points also apply to JIPs. Indeed it is essential that these two documents are fully compatible, and also link sensibly with other documents such as Community Care Plans.

2 *How will accountability to the local community and to users be delivered?*

This follows on from the first question. While it is undoubtedly true that the creation of PCGs and PCTs means that Joint Consultative Committees (JCCs) would have become marginal, there will be a greater rather than a lesser need for consultation and coordination. *The New NHS* drew welcome attention to the need to work with users and with local communities. Mechanisms need to be created to ensure that a dialogue between all the partner agencies in mental health – including the independent sector (the voluntary sector is represented on JCCs) continues.

One option would be to describe a variety of non-bureaucratic mechanisms for achieving dialogue – and much good practice in this area has been developed in recent years – and leave it to local agencies to agree what is best locally. Health Authorities could be required to describe these mechanisms in the HimP. Another would be to create a strategic body which brings together all the key players – both commissioners and providers, but this may risk creating new bureaucracy.

3 *How will charging be dealt with?*

Little has been said about this issue. Social services authorities may, and in some circumstances, must charge for social care whereas charges cannot be made for health services provided by the NHS. The Consultation Paper makes clear that the proposals for new flexibilities will not alter this. The current position in mental health is that social care services provided under Section 117 of the Mental Health Act 1983 cannot be charged for. Mental health social care not provided under Section 117 is treated as all other social care. Thus the distinction between a health service and a social service will remain of crucial importance, particularly to service users.

At present there is something of a geographical lottery in access to long term care for a variety of reasons including the lack of clarity about what is health and what is social care. This is particularly difficult in mental health where rehabilitation services, for example, are hard to classify in these terms. The proposals in the Consultation Paper to require authorities wishing to make use of the new flexibilities to align their continuing care and eligibility criteria, and the guidance which is to be issued next year with the aim of reducing local variations in charging practice, should start to address these issues.

4 *How will pooled budgets work?*

There are a number of issues to be addressed if pooled budgets are to work well in practice. There is a case for creating pooled budgets for both commissioning, and operational service delivery, as well as each level in between. The discussion paper is unclear about how the system will work at the various levels. The senior management arrangements for the pool manager will also need to be carefully thought through. This is acknowledged in the paper, but the precise arrangements require further thought. There are circumstances in which he or she might be pulled in two directions at the same time.

The document states '[lead commissioning] would enable staff in the lead authority to manage a single budget for commissioning health and social care'. Presumably this means that that budget can then be delegated to operational level in the same way as a pooled budget, but

without joint accountability. However, this is not completely clear. At practice level arrangements, including training, will need to be made for single assessments and a single care management process. Some providers have already gone a considerable distance down this road and there is much to be learned from these examples.

5 *How will lead commissioning work?*

Although it is proposed that the lead commissioning agency has the power to commission both health and social care, nothing is said about

- the involvement of or delegation to staff from the other agency
- how to achieve integrated care at an operational level as a result.

So while this proposal may be valuable in focusing commissioning effort and responsibility, it needs further work if it is to address the core objectives of the Consultation Paper. Neither is it clear why anyone would want to adopt the model if their statutory accountabilities remain unaltered. Clarification is needed of why how lead commissioning will work in practice.

6 *How will integrated provision work?*

One-stop shops are an excellent idea for users, but of course they can already be provided through agreements over sharing estate or outposting staff. No new initiative is required. What does require a better legislative framework is the model where a care manager carries out a single assessment for health and social care, and spends a pooled budget to buy services for the client, as already discussed.

It is also unclear from the Consultation Paper who will carry out assessments for health care and social care within integrated providers – and no doubt the precise arrangements will vary locally. Shared training will be required to deliver useful change, as will better arrangements for user involvement and consultation.

Conclusion

The consultation paper provides major opportunities to further develop joint working and to move towards integrated care. Many areas are already working up proposals which will break down organisational barriers, and deliver integrated care packages. The detailed implementation of the proposals will need to enhance and facilitate this trend. This paper has attempted to sketch out the issues which remain to be resolved. Comments or observations are welcome and should be addressed to Dr Andrew McCulloch at The Sainsbury Centre.

What will the Sainsbury Centre be doing to support the development of better joint working?

The requirement now is to focus on the practical steps which commissioners and providers can take to develop and implement better models of joint working – whether or not all the flexibilities mentioned in the consultation paper are implemented. In order to support this, The Sainsbury Centre will

- produce a major report in Spring 1999 on the practical models for change. This will build on existing knowledge of good practice and will go much wider than the legal and administrative framework to focus on the human resource, training and developmental issues as well as structures. It will cover
    - what is happening already
    - what new models could be developed
    - the lessons already learned and an analysis of the opportunities
    - the range of management and service issues which must be addressed.
- hold major conferences in the New Year to address this and other key issues in mental health. The first of these will be a major one day conference to explore the implementation agenda flowing from the Government's new mental health policy. This will take place on Tuesday 17th November at The Royal Lancaster Hotel, London.
- launch a database of service developments containing examples of local models of joint working. This will be available on-line and via telephone from April 1999.
- assist services in developing organisational and support structures based on identified local need, through locality profiling.

Enquiries about conferences should be directed to the Sainsbury Centre conference line on 0171 827 8384, on publications to 0171 827 8385, and about the database project *(Mental Health On-line)* to Wanda Healy on 0171 827 8305.

Reference

1. Parker,C. and Gordon,R. *Pathways to Partnership: Legal Aspects of Joint Working in Mental Health.* The Sainsbury Centre for Mental Health. 1998.

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