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The future of primary care groups and mental health commissioning

Primary care has a substantial role in providing direct mental health care and in referral to secondary services. Recent changes in general practice have anticipated the advent of primary care groups (PCGs) and a rapid transition to primary care trusts (PCTs). These organisations are accountable for commissioning cost-effective evidence-based care in accordance with national standards aiming to benefit patient care.

Primary care and general practice

Primary care is largely synonymous with the work of general practice – health care professionals working in practices and health centres in the community they serve, available to meet patients at their point of need.

Revision of the general practice contract with the NHS in the early 1960s opened the way to investment in premises and the development of working relationships with other health care professionals, such as district nurses and health visitors, plus a movement from 'single-handed' to group practice. List sizes settled to around 2000 patients per full-time general practitioner with typical groups perhaps having four or five full-time partners.

The NHS and Community Care Act 1990 encouraged experimentation in general practice. Some radical practices adopted total purchasing of services, using both NHS and private sector providers. Practice sizes have increased, including some multi-fund groups.

The NHS (Primary Care Act) 1997 consolidates the primary care-led and funded NHS, without the drawbacks of competition, by mandating that integrated commissioning decisions should be taken by PCGs.

Access to primary care may now be by innovative routes such as NHS Direct and NHS 'walk-in centres'. Primary care has a fundamental role in 'gatekeeping' patients' access to secondary and specialist services. Access to a community mental health team (CMHT) requires referral from a primary care agency, usually general practice, sometimes social services or others.

Planning mental health services in primary care

If PCGs and PCTs are to commission effective mental health services there must be careful planning. Planning in partnership avoids the risk of asset-stripping of secondary and specialist services, rendering them ineffective to meet the tasks for which they were designed. This is particularly true for mental health services, where capital and technological investment has been less and where roles are often blurred, overlapping with activity in

primary care. A wide range of stakeholders should be involved, including user and carer representatives.

When planning services stakeholders will require a comprehensive overview of existing services and activity with detailed local demographic detail. This is time-consuming and not always straightforward but can be looked for systematically (Cohen & Paton, 1999). Office for National Statistics (formerly the Office of Population Censuses and Surveys) census data can be obtained through public health medicine at the health authority, including deprivation indices and the incidence and prevalence of common mental disorders and suicide. General practitioner severe mental illness (SMI) registers may exist. If practices do not have contemporary registers of patients with SMI then these should be set up. Prescribing data, mental health provider case-load, note review and practice staff recollection can account for the majority who should be on the register. This is further informed by primary care studies looking at diagnostic frequency and morbidity.

Current activity can be estimated by looking at current use of a range of mental health services. Appointments with general practitioners flagged for mental health, or with counsellors and psychologists, give an indication of practice level activity. General practitioner referral rates to the mental health provider, CMHT and speciality team case-loads, admission rates to the mental hospital and hostel placements indicate use of secondary specialist mental health services. Additional information can be gained from referrals to the voluntary sector, use of accident and emergency departments and walk-in centres or calls to NHS Direct about mental health problems.

PCGs and PCTs

PCGs are organisations typically responsible for populations of 80 000–150 000, consisting of as many as 80 general practitioners and their primary care teams operating from several practice sites. There is an explicit duty of partnership between health authorities, PCGs and NHS trusts to improve the health of, and address the health inequalities in, their community, develop primary and community health services and advise on or commission secondary care services.

Initially, PCGs can function in an advisory capacity to the health authority, which retains commissioning (level 1), or can take direct budgetary control (level 2). Over time PCGs in England and Wales will move toward becoming PCTs, taking full responsibility for local development and commissioning functions, including in-patient care (levels 3 and 4). It is anticipated this will eventually



extend to all PCGs. The final evolution will include the provision of integrated social care (levels 5 and 6) (NHS Executive, 1998).

Providing quality integrated mental health services

Standards across organisations can be assured by a common evidence-based approach sustained by education and training and an agreed supervision structure. The National Institute for Clinical Excellence has a statutory role in the evaluation of drugs, treatments and devices made available on the NHS, for their clinical effectiveness and cost-effectiveness.

PCGs and PCTs are expected to appoint a lead for clinical governance and evolve a clinical governance framework (NHS Executive, 1999; Roland *et al*, 1999). They will be accountable through the health authority to the Commission for Health Improvement. PCGs and PCTs will contribute to the development of health improvement programmes, reflecting local need and national priorities as set out in the National Service Framework for Mental Health (Department of Health, 1999). Clinical practice will be informed by evaluated guidelines, protocols and care pathways.

Mental health commissioning by PCTs

PCTs take on the commissioning function of the health authority. There is a need to provide and commission integrated services to manage three tasks: mental health promotion, the detection and treatment of mental ill health and the management of enduring SMI. For the population served by the PCT there must be equity of access to the full range of mental health services, acknowledging ethnic and cultural needs with the explicit aim of reducing stigma.

Currently the position is mixed. Services delivered vary from advice and counselling to evidence-based psychological therapies (NHS Executive, 2000), psychotherapy and protective asylum. Provision is variably from within primary care or by specialist mental health services. Currently access to services is not equitable – some have a lot, some none at all. There is a need for more – generally.

PCGs/PCTs and mental health trusts

Mental health care is delivered most effectively by multi-disciplinary teams of health and social care professionals. Primary care and mental health trusts have the most developed models of multi-disciplinary team working. A PCG/PCT serving 150 000 is likely to be served by several CMHTs. Thresholds for referral to CMHTs vary within mental health trusts. Mental health trusts will need to provide justification for any local variation in service provision or PCG/PCT commissioners will require a move towards parity.

A PCT will be more than a commissioning group of general practices

If PCTs are to become effective providers and commissioners of mental health services they must evolve an organisational structure and clinical services beyond those found in traditional general practice.

These changes require detailed work around needs assessment and costing. It is a process of evolution rather than revolution and will begin within existing structures. A commissioning forum where health authority commissioners meet with mental health trusts, local authorities, PCG/PCT management, users and carers and other stakeholders enables decisions to be taken in partnership. General practice mental health leads from several PCGs/PCTs can share ideas and strategic thinking with mental health trust and health authority executives.

With so many competing priorities as PCGs develop and move to trust status, it is helpful to establish individuals at each level within the evolving organisation to take responsibility for mental health.

A PCT clinical priority group for mental health is useful, chaired by a PCT mental health lead who can represent the PCT at the commissioning forum. For decisions to be disseminated within the PCT it is helpful to identify practice-level mental health leads. Each practice can evolve its own internal structure describing the relationship between the site lead and the various mental health advisors and practitioners working from the practice.

Describing these roles can enhance general practice liaison meetings with CMHT consultants. The function of these meetings becomes clarified and regular audit of communication style and effectiveness is possible. Each side comes to understand the capacity of each service to deliver the care planned for the patient. The PCT case-load in CMHT or specialist care can be reviewed, aiming to return patient care to the PCT as soon as possible and identifying factors, other than illness severity, blocking this. The CMHT consultant can give advice and feedback to the practice mental health lead and partner general practitioners concerning cases that do not fit an agreed integrated care pathway, or where there is doubt as to the benefits of referral. Joint care plans can be established and reviewed where there is shared care and need for service development discussed.

The PCT mental health lead

This role requires a professional background in mental health care and experience of leading and managing teams. Within the PCT the lead's role is to action the overall mental health strategy within the PCT clinical governance framework. He or she would design job descriptions and training needs for mental health advisers, counsellors and practitioners delivering treatments in the practices and would set up a programme of continuing professional development and adequate supervision arrangements with psychotherapy and psychology in the mental health trust for the practice mental health leads and practitioners.



Practice mental health leads

At practice and site level there should be a nominated mental health practitioner responsible for working with the PCT mental health lead to develop the roles of mental health adviser, counsellor and practitioner.

Mental health adviser – a person trained in the availability of local community resources and who can use directories and databases to help users and carers find information and solutions relating to their particular problems.

Counsellor – a person trained in counselling techniques, who practises according to recognised models and who is open to supervision and peer performance review.

Mental health practitioner – a person who has trained in medicine, nursing or clinical psychology and who has or wishes to gain additional experience in assessing for and delivering psychological therapies, particularly cognitive-behavioural therapy. He or she should be open to training, supervision and peer performance review.

Mental health advisers, counsellors and practitioners will increasingly come from a variety of professional backgrounds and training (Department of Health, 2000a). New graduate mental health workers are proposed in the NHS Plan (Department of Health, 2000b). Mental health practitioners will have to relate to one another in their different teams and between organisations.

Many of these interactions will be managed using tools such as integrated care pathways for the transfer of care at mental health interfaces using best evidence, care planning and audit, and will be guided by clinical governance. In time the role of integrated care pathway manager may emerge, responsible for the quality management of patient care journeys across organisational boundaries (McCull et al, 1998). The evaluation of new service provision will require additional capacity for audit and research, development and dissemination. PCTs are in a position to appoint research and audit facilitators as part of meeting their clinical governance requirement.

Finally, changes to the general practice contract from general medical services to personal medical services opens the way to employing salaried general practitioner partners in 'specialoid' roles and other health professionals working in integrated care teams specifically addressing care needs at the level of the individual.

In summary

The transition to PCTs as commissioners of mental health services offers a new opportunity for planning in partnership and delivering an integrated range of high quality services with equity of access and a reduction in stigma. There is much expertise in existing secondary services that can inform these developments, but there is little spare capacity in mental health trusts. New resources will be required for new services, many of which can be provided directly from within primary care. Some of these will be found in existing practice staff working in new models supported by education, training and supervision. Other resources will come from partnership funding. It is essential that new models are evaluated as part of a research and development initiative in primary care. The legacy of these initiatives should be improved patient care with reduced morbidity and improved social functioning delivered for the majority by cost-effective evidence-based primary care mental health practice.

References

- COHEN, A. & PATON, J. (1999) *A Work Book for Primary Care Groups. Developing an Integrated Mental Health Service*. London: Sainsbury Centre for Mental Health.
- DEPARTMENT OF HEALTH (1999) *The National Service Framework for Mental Health*. London: Department of Health.
- (2000a) *A Health Service of all Talents. Developing the NHS Workforce Consultation Document on the Review of Workforce Planning*. London: Department of Health.
- (2000b) *The NHS Plan. A Plan for Investment. A Plan for Reform*. London: The Stationery Office.
- MCCOLL, A., RODERICK, P., GABBAY, J., et al (1998) Performance indicators for primary care groups: an evidence based approach. *British Medical Journal*, **317**, 1354–1360.
- NHS EXECUTIVE (1998) *The New NHS: Modern and Dependable. Developing Primary Care Groups*. Health Service Circular 1998/139. London: NHS Executive.
- (1999) *Clinical Governance in the New NHS*. Health Service Circular 1999/065. London: NHS Executive.
- (2000) *Psychological Therapies: Working in Partnership*. London: NHS Executive.
- ROLAND, M., HOLDEN, J. & CAMPBELL, S. (1999) *Quality Assessment for General Practice: Supporting Clinical Governance in Primary Care Groups*. Manchester: National Primary Care Research and Development Centre.

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