Community-Oriented Integrated Care

Community-oriented integrated mental health services

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Key messages

- Commissioning needs to be capable of supporting small-scale, innovative organisations.
- Integration should be seen as a way of engaging the value of communities.
- The value of primary care to mental health will be better realised through general practitioner networks.

Why this matters to us

We want to see mental health services improved by the engagement of communities as a means of advancing inclusion and opportunities for social and citizen participation. We are concerned too with

greater value for the contribution of the often small-scale non-traditional services sometimes organised as social enterprises and often more closely and responsively linked to communities than larger, institutionally based provision can be. We see the vital role that primary care can play in this and share a collective desire to see this distinctive role better represented in the range of narratives on integration now rapidly emerging. Our concerns for this spring from two different but, we think, complementary professional perspectives: law and academia, although we share with each other and *LJPC* colleagues first and foremost a commitment to practical development that registers in the lives of people who use services and the communities to which they, like us, belong.

ABSTRACT

Unprecedented levels of cost containment in NHS and social care organisations – together with integration as a policy priority – make this a key moment for fresh ways of thinking about how to commission and provide community-based integrated services that meet the challenge of local accountability and citizen participation. This is nowhere more important than in mental health. Primary care with its local orientation is properly at the heart of this agenda, but there is a need for new forms of leadership for collaboration in the sector. In this context, the contribution of general practitioner (GP) networks is likely to be fundamental. This

paper is a brief discussion of some of the issues associated with GP networks and mental health, set in the context of a round table discussion with three sets of participants at a 2014 *London Journal of Primary Care*/Royal College of General Practitioners conference. The conference provided a forum for capturing a diversity of experience and knowledge and for turning this into a force for critical transformation. This paper describes a contribution to the day.

Keywords: community; GP networks; mental health

Introduction

This paper is one of several that were inspired by a 2014 conference on realising collaborative research and innovation in primary care, facilitated by the *London Journal of Primary Care* and the Royal College of General Practitioners. The conference proved to be a good 'litmus test' for the view that primary care has much more to contribute to improving mental health services in the community than is often evident and that general practitioners (GPs) working more collaboratively together through more formal relationships, could make a significant impact on mental health. The timing for this certainly seems right as the public policy focus on integration and mental health parity invites us to consider, more closely than ever before, the ideas most closely associated with an effective primary care contribution.

New opportunity for mental health

We see the current health and social care environment as a perfect catalyst for looking afresh at mental health in the primary care setting. As commissioners of primary and community care, clinical commissioning groups (CCGs) and NHS England now appear to be committed to the principle that GPs need to work collaboratively if we are to improve the quality of care and the efficiency and effectiveness of provision. This is reflected in the £50 million Challenge Fund, intended to support the 20 pilot GP collaborations linked to other interested networks that are looking at innovative ideas to improve GP access for some seven million patients. Being open to change in the way GPs work together is the first step down the road of changing the way that these services are, in fact, provided.

Further, we are seeing, in increasing numbers of CCGs, a resolve to achieve in their areas an improved level of GP collaboration as they realise that their GPs will otherwise be left behind in a the fast-moving context of provider pluralism. GPs have an obvious knowledge and understanding of their patient population, and commissioners want to see this expertise brought to bear for the benefit of the whole community. This is something with which GPs readily identify in principle, but there is now some urgency to put it into practice as new laws at both national and European level require active consultation with communities in order to determine the services that citizens wish to see commissioned. Alongside this, there is a growing appreciation of the need to find

ways to engage and connect communities and especially members of those whose voices are seldom heard, to address the local health inequalities associated with exclusion.

The continuing and deepening impacts of austerity on services make the next 12 months an absolutely crucial period in which to address the question of GP collaboration and community involvement because local health and care economies can no longer afford to get their planning and implementation wrong.

Integration

Integration is the new watchword for health service development. The report of the Commission on the Future of Health and Social Care in England¹ proposes integration as a 'simpler, graduated pathway of support' to be pursued by means of a 'single ring-fenced budget' and a local commissioner. The regulator *Monitor* has defined integrated care and support as that which is 'person-centred and coordinated ... in which citizens plan care with people who work together to understand their needs and who enable them to achieve, through services that are brought together, personally important outcomes that are subject to their own control'.² Integration is now the guiding principle for regulation.

The legislation is clear on the need for integration: NHS England has the duty to look to secure integrated health provision and integrated health with health-related or social care services where that would improve quality or reduce inequalities in access or outcomes (Section 13N of the NHS Act 2006). It is also clear on the importance of parity of esteem for mental health: the Secretary of State must secure improvement in mental as well as physical health, and in the prevention of mental illness as well as physical illness (Section 1(1) of the NHS Act 2006).

Current and past performance

Despite broad agreement that the commissioning of mental health services has been less effective than might have been expected, it has taken a significant time to begin to address this issue. Clearly, spending constraints and the influence of organisational changes such as the transfer of community health services away from primary care trusts (as they were then) have acted as a brake on changing commissioning patterns, but so too have features such as the way mental health services have been funded. As reported by the HSJ Intelligence Market Briefing published on 20 August

2014,³ the acute sector raced away from mental health with the introduction in 2003 of payment by results, which rewards increased activity financially. Mental health is still largely funded through block contracts where commissioners provide lump sums to providers for the delivery of specific services. This Briefing mentioned how this method of funding can remove much of the ability of the commissioner to ensure quality in provision of services and has led to widespread variation among mental health providers who have adopted their own ways to cope with reductions in contract values.

Leaving aside funding arrangements, we have seen a number of innovative approaches to mental health service redesign, including those based on newly created social enterprises. Although these innovations and the potential for learning from them is well evidenced,⁴ there is evidence too of promising mental health innovation failing to come to fruition due to funds being committed to more traditional hospital care services.⁵ It is likely that funding stream silos create their own limitations for the ways in which the spectrum of mental health need is viewed. Local GP networks are well-positioned to act as catalysts for the whole system of mental health, that is, the well-being of whole communities as well the individual treatment and prevention needed by those community members with more common mental health problems and the smaller, but just as important, number of individuals with serious and enduring problems. Commitment to a vision of community-oriented mental health *and* dedicated funding will be needed if the example of one social enterprise that failed to become operational despite two years of funded development is not to be replicated. There is thus an urgent challenge to use the learning from these and other practice examples to inform how mental health services that can genuinely integrate with person-centred practice in the community are to be designed and commissioned. The *LJPC* conference explored the role that GP networks could take to advance this goal.

Discussion

Our conference table had three very different sets of conversations.

We had prepared a short topic guide and some key questions to stimulate discussion. These were introduced at the start of each conversation, alongside a brief check for validity on three overall assumptions, namely that: (1) mental health was an area worth tackling by GP networks; (2) GP networks could make a practical difference to mental health; and (3) en-

gaged and connected communities are key to integrated practice.

We were keen to stimulate some thought about form and function of innovative mental health services and ways to reduce barriers to improvement. Moreover, we were keen to establish whether different ownership or governance models (e.g. citizen participation in GP networks in the form of social enterprises through stakeholder councils or forums) could make a difference. Last but not least, we were looking for examples of good practice.

Some outcomes

Our conversations confirmed a clear agreement as to the value and agency of GP networks both as a means of supporting good mental health at community level and in its design and ownership. The existence of some community-based provision was acknowledged, but the main concern was of domination of a hospital model. Participants described some innovatory non-hospital aligned community service models, but also many examples of approaches to interprofessional education, communication and governance approaches that are far from patient or community centred.

'Behind the curve'

The current provision of mental health services in the community was described by the delegates as being 'behind the curve', 'binary', 'siloed' or as having 'no joined up dots'. Although examples of specific services with an intended community orientation such as rapid response teams were cited, delegates felt that these offered only a partial solution to community need – and anyway, were few in number. There was wide agreement on the need for community service approaches that are co-designed and produced with communities themselves. Delegates thought that GP networks could really help. A potential crisis is looming through a lack of real involvement by those people receiving services and the services therefore not reflecting what people really need and GP networks could be instrumental in developing local solutions to address it. The idea of connected communities – understanding social and community networks as valued assets in the delivery of care and support – is likely to be an important aspect of such solutions. Many delegates were passionate about the role of primary care and GPs in mental health service innovation and expressed enthusiasm for using GP networks to multiply and replicate examples of inspiring local innovation

Sustainability

There was a desire by most delegates, mental health professionals and GPs alike, to get involved and move mental health service transformation forward, and to increase the range and type of services involved. There was an acknowledgement that this would need some 'muscle' and that it would be a challenge to create quickly new community-based services that are sufficiently robust. Delegates thought that different clusters of practices could pilot community structures and provide oversight of local governance, at a later stage translating what has been learned to other parts of a CCG.

Joint education

GPs and hospital professionals need to work more closely together. Poor communication is holding back patient care. There needs to be more joint training between professionals about clinical issues and also about system integration. The interoperability of software packages is particularly important to enable efficient data flow, and to achieve a shared understanding of the data protection principles.

Pooled budgets

There was an urgent need for 'silo' working to end – and for health and wellbeing boards to become more alive to the needs of people with mental health issues. Transferring money between organisations across the health and social care divide and using Section 75 powers to pool budgets, delegate responsibilities and create better integration is called for. The potential for GP networks to form new provider vehicles such as social enterprises, to compete and win work where their value was proven and to articulate the advantages of such local models is a key issue. Delegates agreed, however, that the challenge of integration is not solely or even principally about budgets and skills, or even about the integration of physical and mental health. Rather, integration demands a different way of looking at the relationship between communities and services and new ways of capitalising the value of both when they are conjoined. This is fundamentally important in mental health where recovery, citizen participation and inclusion are established watchwords. Our delegates agreed that GP networks offer one important new route to its achievement.

Conclusion

The conference provided a forum for capturing a real diversity of experience and knowledge and turning this into a force for critical transformation. The impact of unprecedented cost containment and policy shifts towards new models of delivery make this a key moment for fresh ways of thinking about opportunities and possibilities. This is nowhere more important than in mental health. Primary care with its community orientation is at the heart of this agenda. Integration, as a community-oriented mental health service, offers a route to realising the value of primary care, for aligning within the local context boundaries that otherwise impede the effective delivery of holistic services and prevent communities from becoming part of the mental health solution. In this context, the contribution of the GP networks is fundamental.

GOVERNANCE

This paper is a personal view of the authors and which has been peer reviewed by other sub-editors of the *LJPC* and which has been read and contributed to by those who have been acknowledged below.

CONFLICTS OF INTEREST

None.

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