Mental Health Network
NHS CONFEDERATION

briefing
December 2013 Issue 269

Mental health and community services

A marriage made in heaven?

Key points

- There is a growing trend for mental health organisations to deliver an increasingly diverse portfolio of services.
- In some organisations, income from non-mental health services exceeds that from mental health service provision.
- MHN survey respondents talked about taking a stepped approach to integrating care pathways, starting with one clinical service or locality and then building on this.
- Boards need to be assured that both physical and mental healthcare is good and safe in proportionate measure.

Mental health organisations are delivering an increasingly diverse portfolio of services. A Mental Health Network (MHN) survey of its members revealed that two thirds of respondents are delivering non-mental health services, with others interested in doing so in the future. The diversification of mental healthcare provision raises a number of questions for a sector that has historically argued the case for delivering 'specialist' mental health services.

This *Briefing* shares the findings from the MHN survey and explores the opportunities and good practice currently developing in 'combined' or 'integrated' trusts, as well as the challenges. It considers whether this growing trend is good for mental health and community services and what the consequences might be.

Background: transforming community services

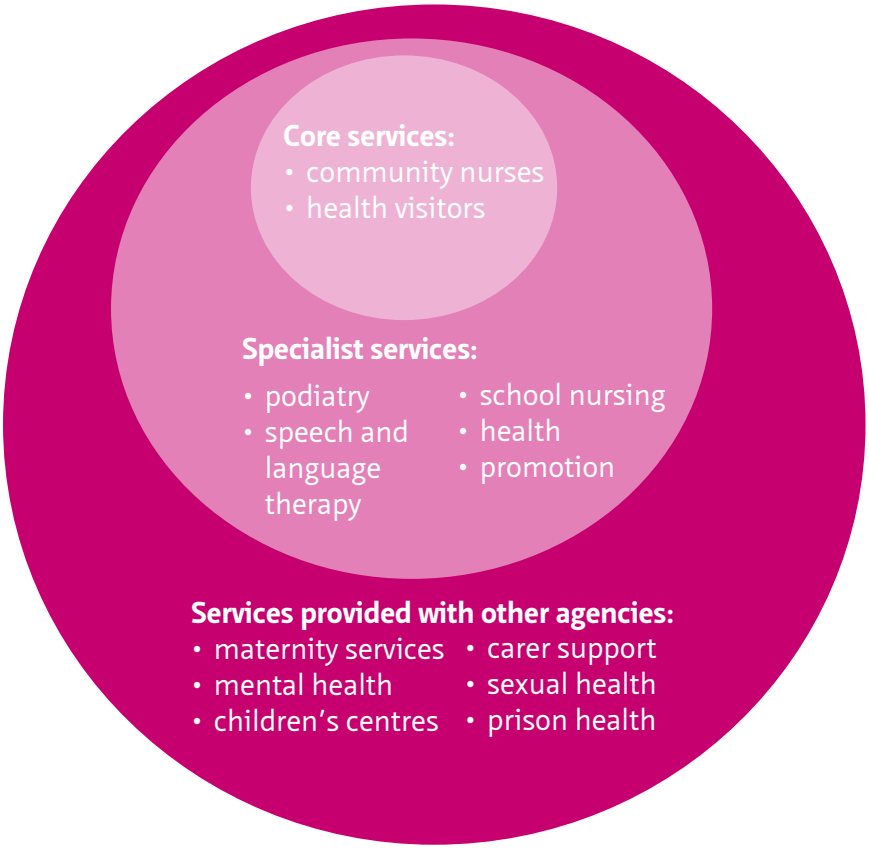
Prior to 2010, the majority of community physical health services were delivered by staff directly employed by primary care trusts, although some services were provided by independent sector and not-for-profit organisations, as well as some acute hospitals. In 2009, *Transforming community services: enabling new patterns of provision* (TCS) called for primary care trusts to focus on commissioning and to separate their provider arm functions to other organisational models.

Under the TCS programme, there was no national blueprint for an organisational model for community services. Change was to be determined by local decisions, supported by some guiding principles – that services should be high-quality, personal, responsible, accessible and tailored to meet

the needs of communities and individuals. New models emerged, including community heath trusts and social enterprises.

The TCS programme was a catalyst for the opening of the market to new entrants. Community health services, covering a wide range of services (see diagram to right), costing over £11 billion per annum,[1] are delivered by different organisational models and contracts, including mental health providers. An initial scoping exercise by the MHN suggested that about half of all statutory NHS mental health organisations have taken on community services from their primary care trusts under the TCS programme.

Community health services



Realising the benefits of community health services: making a difference to real communities. The NHS Confederation, 2012

The Mental Health Network survey

In May 2013, the MHN conducted a survey to better understand the scale and scope of non-mental health provision by its members, including the opportunities and challenges posed by current and emerging models of service provision and the future direction of travel for the sector.

All members of the MHN were surveyed (64 organisations in 2012/13). Twenty two responses were received – a response rate of 34 per cent. Eighty six per cent of responses were from NHS and foundation trust organisations.

The scale of non-mental health provision

The survey revealed a trend for mental health providers to diversify the provision of their services, with two thirds of respondents saying that they currently provided non-mental health services. Of those that did not, the majority were interested in doing so in the future.

Almost half (43 per cent) of organisations delivering diverse mental and physical health services received between a fifth and a half of their total income from non-mental health provision.

For 28 per cent of respondents, income from non-mental health services equalled, and in some cases exceeded, their income from traditional mental health provision. This indicates the changing landscape of NHS mental health delivery.

The scope of provision

Non-mental health services delivered included: back-office functions, such as payroll and human resources; walk-in centres; acute hospital therapy services; stroke and neurological rehabilitation; children's services; wellbeing; learning disability; and prison/offender healthcare.

The impact on care delivery

The MHN was keen to find out the impact on practice and care

delivery, and what the positive and negative results might be, of delivering mental health and community services in the same organisation.

Most respondents cited changed practice, some very positively in terms of care becoming more holistic. Others cited closer collaboration with colleagues across different teams as a benefit. This included increased awareness, understanding and management of mental health and physical needs.

Delivering more integrated care was also a key ambition of respondents. Some described taking a stepped approach to integrating pathways, starting with one type of clinical service or locality and then building on this. Having begun some integration of workforce and clinical pathways, a number of organisations cited streamlining and integrating management functions as the next focus for change.

Challenges

In terms of challenges, respondents talked about organisational identity – in some cases income from non-mental health services equaled, or exceeded, the income their organisation derived from mental health service provision. There was a feeling that a clear narrative is needed about the 'type' of healthcare organisation staff are working in. Others talked about concerns of 'marginalisation' – that mental health services might be subsumed into, or 'lose out' to, larger community services, and that clinical expertise could be at risk of becoming diluted.

Future opportunities

While 90 per cent of respondents saw opportunities for growth in their organisations, two thirds said they would probably not retain all contracts beyond the three-year period. The most common reason given was the competitive environment and tendering process.

Future opportunities cited included developing more integrated services across different sectors, including physical health, social care, mental health, prisons and offender health and long-term conditions. The potential for joint ventures and wider partnership working with the for-profit and not-for-profit sectors, as well as with acute trusts and social care, was referenced by a number of respondents.

Analysis and discussion

What are the implications of the changing landscape of NHS mental health provision? Key issues for organisations delivering both mental and physical health are outlined below.

Improving outcomes

People with mental health problems commonly experience poor physical health. Long-term severe mental illness is associated with high levels of physical illness, significantly reduced life span and poor access to health promotion and intervention.[2] Thirty per cent of people with a long-term physical health condition also have a mental health problem.[3] Organisations which deliver both mental and physical health have the opportunity to improve access to care and treatment for vulnerable groups.

> 'The potential for joint ventures and wider partnership working was referenced by a number of respondents'

There are many examples of positive changes in practice, where physical and mental health staff collaborate more and have increased awareness, understanding and management of mental health and physical needs.

Over time it will be interesting to see if organisations providing both physical and mental healthcare will be better able to meet some of the key aims of the mental health strategy: supporting the parity of esteem agenda; providing more opportunities to break down stigma in mental health; and delivering more on the recovery journey.

It is important to note that greater competition was introduced at the same time as the TCS programme. As a result, service contracts have become increasingly fixed-term rather than open-ended, to allow for periodic market testing. It is these agendas which have opened the door for mental health organisations to diversify provision, rather than a clear policy direction.

To what extent are decisions for organisational growth into different sectors being *driven* by improving service user and patient outcomes? In an increasingly

competitive environment, with challenging financial times, and where organisational growth is an important part of health 'business', drivers could be in danger of becoming opportunistic and financial rather than altruistic.

Risks

New business brings opportunities and growth but also risks. There is a steep learning curve when taking over a new business.[4] This can result in costs that might outweigh any economies of scope and scale. Furthermore, bringing together different organisations might be seen as a distraction from other tasks.[5] While some argue that times have changed and mental health should no longer deliver care in a silo, others feel that mental health delivers care best without distractions.

Organisational culture and developing shared objectives

Cultural differences can present significant obstacles to creating alignment between different groups of clinicians and organisations. Time is needed to develop a coherent organisational culture and shared objectives. It is important to understand the culture of physical and community services in order to develop trust between staff and build a shared understanding of what is important about good care.

A clear narrative is also needed to tell patients, service users, carers and the public about what type of organisation is serving the community.

Marginalisation and dilution of clinical expertise

Delivering physical and mental healthcare in the same organisation can help mainstream mental health within physical health services. However, there were concerns that mental health might become subsumed by, or lose out to, larger community services, and return to having a 'Cinderella' status.

There were also fears that clinical expertise might become diluted. Strong clinical leadership across the whole range of services was considered essential.

Enhancing governance

Mental health providers are well placed to take on community services, with their knowledge and experience of delivering mental health services in the community, managing risk and partnership working. A number of mental health leaders also have experience of leading physical acute or community services. However, it is important that the differences between mental health services and community services are not ignored. Boards need to be assured that both physical and mental healthcare is good and safe in proportionate measure.

Knowing how to deliver safe and effective community-based services provides a solid foundation to delivering mental health and community-based physical services. However, having relevant clinical knowledge and understanding is a recurring theme in conversations about enhancing governance arrangements. For example, Cheshire and Wirral Partnership NHS Foundation Trust made new appointments to its board to embed robust challenge and appropriate expertise in the new organisation. The board also took time to visit and understand the physical health services and community teams. Staying informed through both 'hard' and 'soft' data was considered essential for robust governance (see case study on page 5).

'While some argue that times have changed and mental health should no longer deliver care in a silo, others feel that mental health delivers care best without distractions'

Following the cases of failings in care at Mid Staffordshire and Winterbourne View, there has been a renewed focus on assuring standards of care in all settings. The Care Quality Commission (CQC) has launched its new strategy and is developing new approaches to review and inspect all health and social care organisations. Robust quality assurance and safeguarding processes for these emerging mental and physical organisational models will be of key interest to the CQC.

Case study: Developing shared objectives

While mental health remains the biggest contributor to Nottinghamshire Healthcare NHS Trust's income, physical health is a core part of the trust's business and identity. For the last three years the trust has promoted itself as "Positive about integrated healthcare", inclusive of mental health, learning disability and community physical services.

Despite some initial staff concerns that there would be a move away from core mental health 'business', the trust champions mental health as much as ever.

Staff were told: "... while suicide is increasing, the bigger danger for people with mental health problems is their physical health... Integrated care provides the opportunity to reduce these health inequalities and support the whole person to be treated, not just the symptoms."

As Mike Cooke, chief executive, says: "Patients don't care who delivers their care, they just want a service to treat and keep them well."

For more information, contact **communications@nottshc.nhs.uk**

Case study: Enhancing governance

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) provide primary and specialist mental health, learning disability and drug and alcohol services across Cheshire and Wirral.

In April 2011 the trust acquired community physical health services in West Cheshire.

To enhance delivery of services and increase partnership opportunities, CWP moved to a locality structure with clear lines of responsibility, governance and accountability. This provides assurance to the board that the organisation is delivering good and safe care across all services.

New senior roles (such as an associate director of nursing and therapies for physical health) were created to support the additional services. A non-executive director of the primary care trust joined CWP as an adviser to the directors, to enhance assurance processes during, and for two years after, the transfer of services.

To support ongoing assurance, unannounced board visits have been introduced for community teams. An executive or associate director, a non-executive, a governance lead and a lived experience advisor visit each locality and specialty. Visits assess areas of compliance by sampling patient records, talking to staff and service users, reviewing the environment plus any incident data relevant to the team. Feedback is provided to staff members involved and a red, amber, green rating determined for each of the CQC's Essential Standards of Quality and Safety. Any gaps in compliance are followed up by an action plan written by the service.

CWP West now encompasses both mental and physical health services, employs approximately 1,376 staff and has an annual income of £46 million; £20 million of which is attributable to physical health.

For more information, contact **David.wood@cwp.nhs.uk**

Moving towards integration

Integrating care is not easy. It can require changing practice, process and culture, and it takes time.

MHN survey respondents talked about taking a stepped approach to integrating care pathways, starting with one clinical service or locality and then building on this. Some described a synergy between teams delivering long-term conditions care. People are being kept out of hospital or having lengths of stays reduced and staff across the different sectors feel supported to deliver more holistic care. These different models of care are pushing innovation. Members have also told us how they see real opportunities for working in various partnership arrangements to deliver integrated care.

Prison health

Prison health is one area where some organisations are making a difference to people's physical and mental healthcare needs through integrated care. Prisoners often have high health and social care needs – they may be homeless, have substance and alcohol misuse problems and low literacy. Taking people out of prison to attend health appointments can be a challenge. Care UK, which manages 20 prison health services, often comes into services which have been previously delivered by multiple subcontractors, including primary care (sometimes split into general practice and nursing), physiotherapy, Improving Access to Psychological Therapies (IAPT), radiography, secondary care and mental health. Substance misuse services have also typically been delivered by two separate teams, one team delivering clinical care and another, run by the prison itself, delivering addiction counselling/behaviour change. Under a single accountable provider model, developed by working with commissioners, Care UK has been able to deliver more integrated care in prison settings, which draws more of a parallel with services delivered in the community.

'Prison health is one area where some organisations are making a difference to people's physical and mental healthcare needs through integrated care'

However, with a significant number of organisations doubting that they will retain current contracts in three years, largely due to the competitive marketplace and tendering process, it is not clear what impact this will have on services in the longer term. Will the efforts made to deliver improved care pathways and more holistic care be lost, paused or recede if contracts are not retained? Can new contractors easily pick up the gauntlet of integration, or will integration fall into fragmentation while new contractors establish new partnerships?

Case study: Person-centred, integrated care

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) continues to integrate Cheshire West and Chester local authority provider services and the Cheshire and Wirral Partnership physical health teams. Services, clustered around a group of GP practices, include district nursing, community matrons, podiatry, physiotherapy and mental health services, social services and children's services.

There is a single point of contact for referrals and a single assessment process. Care is person-centred irrespective of organisational boundaries, and services are available and flexible according to the needs of the GP community. As Sheena Cumiskey, chief executive, says: "CWP West Cheshire has built on the individual strengths of its services through the integration of both mental and physical health services, exploiting shared synergies and adding value to patient care pathways and service delivery outcomes."

For more information, contact **David.wood@cwp.nhs.uk**

Mental Health Network viewpoint

Mental health providers have stepped into the wider marketplace and are delivering a diverse portfolio of services with a drive to deliver more holistic care.

Delivering both physical and mental healthcare from the same organisation makes sense and 'fits' with person-centred and holistic care. However, it is also a 'retro fit'. The policy drivers in the Mental Health Strategy (2011)[6] frame the context for greater alignment of mental health and physical health services and to deliver more holistic care. However, there was no major plan or policy shift for mental health providers to take on non-mental health services to deliver this, or indeed any other, strategy.

Despite this, there are some promising opportunities and good practice emerging in combined/integrated trusts.

It is not yet clear whether there are any pitfalls in the acquisitions of physical health services by mental health organisations. Indeed, if the ambition is integrated care, is it legitimate for acute trusts to acquire mental health services? There are some concerns that mental health might return to 'Cinderella' status, and there are risks too for community services to be marginalised. Might the competitive marketplace threaten the reality of longer term integrated care? Ensuring these emerging organisations can deliver safe and effective mental and physical healthcare in proportionate measure is a challenge and one that will be of interest to the Care Quality Commission.

The Mental Health Network is keen to explore the opportunities and challenges further. If you have any comments on the issues raised in this *Briefing*, or have further good practice case studies to share, please contact claire.mallett@nhsconfed.org

References

1 NHS Confederation's Primary Care Trust Network (2009) *Community health services: making a difference to real communities*.

2 Mental Health Network (2012) *Investing in emotional and psychological wellbeing for patients with long-term conditions and medically unexplained symptoms*.

3 Cimpean D., Drake R.E. (2011) 'Treating co-morbid medical conditions and anxiety/depression', Epidemiology and Psychiatric Sciences, 20, pp141–150.

4 The NHS Confederation (2005) *Building integrated care. Lessons from the UK and elsewhere*.

5 ibid

6 Department of Health (2011) *No health without mental heath; a cross-government mental health outcomes strategy for people of all ages*.

Mental Health Network
NHS CONFEDERATION

The Mental Health Network

The NHS Confederation's Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors.

The MHN works with Government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

For further details about the work of the MHN, visit **www.nhsconfed.org/mhn**
or email **mentalhealthnetwork@nhsconfed.org**

Further copies or alternative formats can be requested from:
Tel 0870 444 5841 Email publications@nhsconfed.org
or visit www.nhsconfed.org/publications

Registered Charity no: 1090329
Stock code: BRI026901
recycle

NHS CONFEDERATION

The NHS Confederation
50 Broadway London SW1H 0DB
Tel 020 7799 6666
Email **enquiries@nhsconfed.org**
www.nhsconfed.org

Follow the NHS Confederation on Twitter:
@nhsconfed