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Subject: Community Mental Health Services

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1. An Overview of the Structure of Mental Health Services

(a) The following is an overview of the structure of mental health services to provide the broader context within which community mental health services operate.

(b) Across England, 90% of those receiving care for mental health problems do so within a primary care sector, yet around 80% of mental health NHS spending is spent of inpatient services. The last 30 years have seen a scaling back of psychiatric hospital services[1].

(c) GPs treat many patients, and usually refer those they cannot help directly to community mental health teams (CMHTs) or psychiatric outpatient clinics. CMHTs are the main source of specialist help for mental health problems. These teams can include social workers, community psychiatric nurses, doctors, psychologists, occupational therapists and support workers.

(d) The people for whom CMHTs provide services can be divided into two groups:

1. Patients with time limited disorders who can be referred back to GPs after a certain period (weeks or months);

2. Patients, a substantial minority, who will remain with the team for a number of years for ongoing care and monitoring[2].

(e) The details around structure, and indeed name, of local teams are down to local discretion.

(f) CMHTs assess and monitor mental health needs using two specialist systems – care programme approach (CPA) or care management. The CPA has been part of mental health services since 1991 and describes

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[1] The NHS Confederation, *The NHS Handbook 2009/10*, pp.101-103.
[2] The Department of Health, June 2002, *Mental Health Policy Implementation Guide Community Mental Health Teams,* p.7, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_085652.pdf

the process by which mental health needs were assessed, care plans developed and reviewed[3].

(g) Some of the ways in which mental health services have been developed in the community include[4]:

1. Early intervention teams which aim to treat psychotic illness during its early onset.

2. Assertive outreach teams to provide intensive support for those difficult to engage in traditional services.

3. Crisis resolution home treatment teams (CRHTs) providing acute care in patients' homes in crises (a 24-hour service).

(h) The introduction of CRHT teams formed part of the 1999 National Service Framework for Mental Health[5]. The intention was to ensure inpatient care was used appropriately. CRHT teams were to carry out a 'gatekeeping' role for inpatient mental health services. Where appropriate, CRHT teams were to provide intensive support/acute care for people with mental health crises in their own homes. The provision of this service was also intended to enable earlier discharge from acute settings.

1. CRHT teams are usually made up mainly of mental health nurses, with input from consultant psychiatrists, social workers, occupational therapists and psychologists.

2. Many teams around the country evolved from previously existing services, such as primary care crisis intervention teams, day services and A&E Mental Health Teams.

(i) Recent years have also seen the development of the Improving Access to Psychological Therapies (IAPT) programme aimed at extending 'talking therapies' and encouraging provision outside hospitals.

(j) In the acute sector, acute admission wards provide inpatient care with intensive support for patients in periods of acute psychiatric illness. Inpatient Assessment Units assess functional and organic type illness in older adults, and take referrals from Community Mental Health Teams for Older People, GPs and Consultant Psychiatrists. Patients who are in an acutely disturbed phase of a serious mental health

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[3] The Department of Health, March 2008, *Making the CPA Work for* You, p.5, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_083652.pdf

[4] The names given to services can vary between areas of the country.

[5] Available at: http://collections.europarchive.org/tna/20100509080731/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf

disorder, are detained in designed Psychiatric Intensive Care Unit (PICU) facilities.

(k) Other mental health inpatient services aim to provide rehabilitation services and provide care to people with an enduring mental illness and for whom a residential placement in the community has been judged to be unsuitable.

(l) Forensic mental health services are there to deal with patients whose behaviour is beyond the scope of general psychiatric services and who may require a degree of physical security. Some will be mentally disordered offenders. These services fall into three categories:

1. Low-security services, often near general psychiatric wards in NHS hospitals.

2. Medium secure services operating regionally with locked wards.

3. High-security services provided by the three specialist hospitals of Ashworth, Broadmoor and Rampton.

(m) Child and Adolescent Mental Health Services (CAMHS) services are arranged in four linked tiers. These range from tier 1 services which contribute to mental healthcare, but where it is not the primary function, such as schools, to tier 4 dealing with the most severe and complex cases and includes inpatient and specialist services such as eating disorders.

(n) According to the Department of Health Business Plan 2011-2015, a cross-government strategy for mental health services and public mental health will be published in December[6].

2. Mental Health within the NHS Financial Framework

(a) Under the current system, Primary Care Trusts control around 80% of the NHS budget. In 2010/11 this amounted to £84 billion (out of a £103 billion NHS budget). This is allocated to PCTs using a weighted capitation formula. £26 billion will be spent using Payment by Results (PbR). The other £58 billion includes prescribing, primary care and those health services not currently included in PbR, such as mental health.[7]

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[6] Department of Health Business Plan 2011-2015, p.13, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121413.pdf

[7] The Department of Health, September 2010, *A Simple Guide to PbR*, pp.62-63, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

(b) Mental health has been identified as the main priority for the expansion of PbR[8]. *High Quality Care for All* contained a promise to have a mental health currency available for 2010/11 and this was met.[9] The NHS White Paper contained the promise to "implement a set of currencies for adult mental health services for use from 2012/13"[10]. The financial framework being developed for mental health services will operate differently to PbR for acute services.

(c) The distinction between a currency and a tariff is as follows:

1. "Currencies are the unit of healthcare for which a payment is made. They can take a number of forms, covering different time periods – for instance, in acute physical PbR, outpatient attendances are paid on a contact basis, whilst for long term conditions we are looking to develop annual payments adjusted for complexity, which would be more like the care cluster approach. Our initial commitment in mental health is to develop currencies that are being used nationally.

2. "Tariffs are set prices for a given currency unit. The collected nationally determined prices for HRGs are sometimes referred to as the tariff. We have committed to examining the case for a national mental health tariff following the establishment of national currencies. Without a national tariff, prices for a given currency can be set locally or regionally (i.e. at SHA level)."[11]

3. HRGs, Healthcare Resource Groups, are the chosen currency for acute healthcare in England. They are "standard groupings of similar treatments which use similar levels of healthcare resources."[12]

(d) The national mental health currency published in 2010/11 is the 'care cluster'. It was developed by the NHS in the North East and in Yorkshire and Humber.

1. "(T)he clusters identify patient need over a given period of time, and apply to both admitted patient and community care. They therefore balance the risk between commissioners and providers. Commissioners do not have to pay extra for each

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[8] Ibid., p44.
[9] Ibid., p.44.
[10] The Department of Health, July 2010, *Equity and Excellence: Liberating the NHS*, p.25, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
[11] The Department of Health, February 2010, *Payment by Results Guidance for 2010/11,* p.95, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf
[12] The Department of Health, September 2010, *A Simple Guide to PbR*, p.20, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_120254.pdf

contact and intervention. Providers know they will be get paid for each patient they care for and they also have an incentive to innovate and support the patient in the most cost effective setting. "[13]

2. "Mental health providers will allocate their patients to the care clusters by the end of 2011. In 2012-13 the clusters will be used as the contract currency, with local prices agreed."[14]

3. There will be exceptions to the services covered by the care clusters, such as CAMHS, secure services, learning disability services and specialised services.[15]

(e) A number of specialised services where the number of affected patients is relatively small are commissioned either regionally by one of the ten Specialised Commissioning Groups, or nationally by the National Commissioning Group. In mental health this includes secure services and some personality disorder services.

3. The Care Quality Commission survey of community mental health services.

(a) On 14 September 2010, the Care Quality Commission published a national survey of community mental health services. The survey involved 17,000 services users at 66 NHS Trusts between July and September 2009. The briefing note by the CQC outlining the national results can be found at Appendix 1[16] and the report on Kent and Medway NHS and Social Care Partnership Trust can be found in Appendix 2.[17]

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[13] Ibid., p.44.
[14] Ibid, p.44.
[15] The Department of Health, February 2010, *Payment by Results Guidance for 2010/11,* p.102, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf
[16] The Care Quality Commission, September 2010, *Supporting Briefing Note: Community Mental Health Survey 2010*, http://www.cqc.org.uk/_db/_documents/MH10_Briefing_note_v7_FINAL_201010262348.doc
[17] The Care Quality Commission, September 2010, *Survey of people who use community mental health services 2010 Kent And Medway NHS And Social Care Partnership Trust* http://www.cqc.org.uk/_db/_documents/KentAndMedwayNHSAndSocialCarePartnershipTrust_RXY_MH10.pdf