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About Humana

Humana Europe is a provider of commissioning services and support to NHS Primary Care Trusts. Headquartered in London, with a developing regional network, we are a clinician-led organisation with expertise in health service design, data and knowledge management, contracting, performance management, communications and engagement, and motivational programmes that promote healthy behaviour.

Humana Europe is a wholly owned subsidiary of Humana Inc, a health benefits company with more than 11 million members and 22,000 employees headquartered in Louisville, Kentucky.

With a history of adapting, innovating and implementing best-of-breed solutions for the healthcare sector, we have developed tried and tested strategies for health and healthcare organisations to improve the patient experience and reduce health inequalities.

About RDMH

RDMH is a service and workforce development organisation, specialising in all aspects of mental health and related areas, particularly learning disability and integrated care. RDMH was established in 2006 to develop further the previous service, workforce and organisational development functions of the Sainsbury Centre for Mental Health (SCMH) when the latter refocused its work to prison mental health and employment.

Contact us

We welcome your views. This white paper can be reviewed on our website at humana.co.uk
Send us an email to add to the debate: info@humana.co.uk

Humana
Discussion
Paper
Episode 1

World Class Mental Health Commissioning

From vision to practice

HUMANA®

Mental health matters

We expect commissioners to be the catalyst for service transformation and health improvement locally, making the best use of the levers available to them including competition, choice and the new contracts

NHS OPERATING
FRAMEWORK 2008/09

World class commissioning sets PCTs and their partners an ambitious and visionary standard to aspire to when developing local frameworks for commissioning healthcare in the future. Successful commissioning requires a strategic and long-term approach, with a clear focus on delivering improved health outcomes. It is based on open and innovative partnerships, using evidence-based approaches and with access to outstanding skills in negotiation, data analysis and performance management.

It's a huge challenge, yet the end results will be worth the effort. World class commissioning has the potential to create a world class healthcare system – one that is integrated, seamless and which centres around the needs and experience of the patient, giving individuals more opportunities to engage with their own health and wellbeing. That is our vision. And that is the subject of this discussion paper, a collaboration between Humana, and Research and Development in Mental Health (RDMH). In it, we draw on the respective knowledge of both US and UK systems to explore how mental healthcare will be affected by world class commissioning. It marks the start of a journey from vision to practice.

Mind/body connections

Even the most confirmed dualist would acknowledge the intimate connections and mutual influences between mind and body. Yet we have become accustomed to using disparate systems for treating mental and physical health.

As a result, we experience both poorly managed mental health problems in the physical health system, and poorly managed physical health problems in the mental health system. This not only creates negative effects on patients, it means seriously adverse effects on the systems too, such as inefficiencies, redundancies and costs that a more integrated approach to care would eliminate.

The integrated experience of the patient is crucial to the reform of our healthcare system, and developing a "patient-centred" healthcare system has been on the national agenda for five years. Yet until we begin to talk seriously about the integration of our physical and mental health systems we will be unable to achieve our goal.

Time for a different approach

Physical and mental health go hand-in-hand. An obvious example of this is depression. If someone is ill, they can also become depressed, but they can also suffer physical illness because of depression. Their experience is not fragmented, discontinuous, and segregated, yet the care they receive can be all of these things.

The importance of tackling non-communicable chronic disease has received well-deserved attention in the last few years. Yet the most impactful non-communicable diseases – disorders of stress, anxiety, and depression – are invariably afterthoughts. It's time to focus on mental health.

Mental illnesses affect and are affected by chronic conditions such as cancer, heart and cardiovascular diseases, diabetes and HIV/AIDS. Untreated, they can bring about unhealthy behaviour, non-compliance with prescribed medical regimens, diminished immune functioning, and poor prognosis. Patients whose stress and anxiety are not being managed may not respond as well to treatment, or adhere to their treatment plans, or recover as quickly or fully as those in good mental health. Stress, anxiety, and depression lurk behind many unhealthy habits such as over-eating, drinking, smoking, and inactivity. These will eventually take their toll on health, and create enormous burdens on the healthcare system.

The costs of mental health

Hundreds of millions of people worldwide are affected by mental health problems. In 2002 WHO estimated that 154 million people globally suffer from depression and 25 million people from schizophrenia.

In the UK, mental health issues affect approximately one in six people at any one time. Nearly one third of GP consultations are related to mental health problems¹, and mental health services account for approximately 12 percent of NHS spending². These familiar statistics represent the visible prevalence of mental health issues and the impact on the NHS. However they cannot be looked at in isolation.

Severe mental illness must be recognised as one of the most complex long term conditions. There is strong evidence to suggest that people with schizophrenia or bi-polar illness have significantly diminished health horizons compared to someone who does not have a serious mental illness.

- On average their life expectancy is reduced by 10 years
- They are twice as likely to die from coronary heart disease, and diabetes
- They are four times more likely to die from respiratory disease
- They are likely to have a higher incidence of heart disease, stroke, hypertension and epilepsy
- They have a 50 percent lower chance of survival from cancer

Research indicates a strong association between many physical health problems and depression³, and that depression is associated with poorer outcomes, lower levels of self-care⁴ and increased use of hospital beds⁵.

In addition, there is strong evidence that a large proportion of secondary care resources are used by frequent attenders, whose symptoms remain

medically unexplained. Although they can be discharged from secondary care, many are often subsequently referred to and continue to attend another speciality. There is growing evidence of a high prevalence of psychiatric morbidity in frequent attendees and those presenting medically unexplained symptoms in both primary and secondary care. 25 percent of patients with chest pain who come to hospital emergency departments have a panic disorder⁶. Half of patients seen in cardiology and neurology have medically unexplained symptoms⁷.

This research highlights the negative impacts of a disjointed and inefficient health system both at individual level and, more widely, across the health economy. It demonstrates the need for integrated services which meet the whole person's needs and empower the individual to take responsibility for his or her health.

Severe mental illness must be recognised as one of the most complex long term conditions



How do we do things differently?

The spotlight is now particularly on primary care but also on stimulating a more diverse range of services in both the statutory and third sector

There are many opportunities to improve the mental health of individuals and communities, through work with parents and families, in schools, in the workplace and in local neighbourhoods. Even small improvements in mental wellbeing can achieve significant improvements in physical health, productivity and quality of life. These in turn bring cost benefits to the healthcare system.

Thankfully, the policy spotlight has shone brightly on mental health services across the UK in recent years. In England, the National Service Framework (NSF) has supported tremendous strides in de-institutionalisation and in the development of community services for people with the most serious mental health problems. There is now a comprehensive raft of policy and evidence to support the next steps needed.

On a cautionary note, however, anyone with experience of the UK mental health system will know that substantial and complex challenges remain. Furthermore, history has a tendency to repeat itself: 'although we seem to know what the key issues are, we also seem remarkably unable to solve them, as the same themes and concerns keep recurring throughout the history of mental health services⁸. For example, despite the political focus, policy development and additional funding that mental health services have attracted in recent years, the experience of service users tells us that significant problems persist⁹. What's needed are more radical shifts in policy, planning and delivery that build on the significant progress achieved under the NSF to date.

What's next?

The Sainsbury Centre for Mental Health has set out a collaboratively developed vision for the future of mental health, which predicts that by 2015 mental wellbeing will be a concern of all public services¹⁰.

Key components include comprehensive mental health promotion and emotional literacy programmes; integration of mental health into ordinary health and other services; extended

cross-sector collaboration; diversified acute care provision; expanded employment opportunities and increased use of direct payments and individualised budgets, so that people suffering from severe mental health have more control in choosing services that are right for them.

As we move into a 'post NSF era', there are significant opportunities, underpinned by existing policy, for more integrated and system-wide or cross-sector approaches to the commissioning and delivery of mental health support. Alongside the consolidation of new specialist services in the secondary sector, there is an increasing focus on the mental wellbeing of the community as a whole. Recovery and social inclusion principles acknowledge the effect of mental health problems on the wider context of people's lives. The imperatives of choice, equality and user empowerment derive from a recognition of the variation in people's experience of mental health and mental health problems. In service development terms, the spotlight is now particularly on primary care but also on stimulating a more diverse range of services in both the statutory and third sector.

These opportunities challenge existing models and systems to think much more broadly about mental health. The starting point here must be a focus on health and on the evidence base regarding its determinants. Mental health tends to be considered in terms of mental health problems, when it should be seen as a positive resource of individual, social and economic value which needs to be nurtured¹¹. Evidence tells us that proactive factors in mental health include physical health, physical activity, employment, healthy eating, social capital, social support and participation in society¹². When an individual experiences mental health problems, these factors become vulnerable. The loss of any of them, in turn, increases the vulnerability of that individual to further ill health. Yet crucially, a focus on the skills and resources required to promote these factors for individuals and communities remains un-prominent in many health and social care economies in western societies.

If we consider evidence-based interventions as a pyramid (see fig 1 below) it is probably fair to say that the attention of mental health service providers and commissioners has, by and large, been focused on the top two tiers in recent years.

Based on work done by Dr Steven Laitner

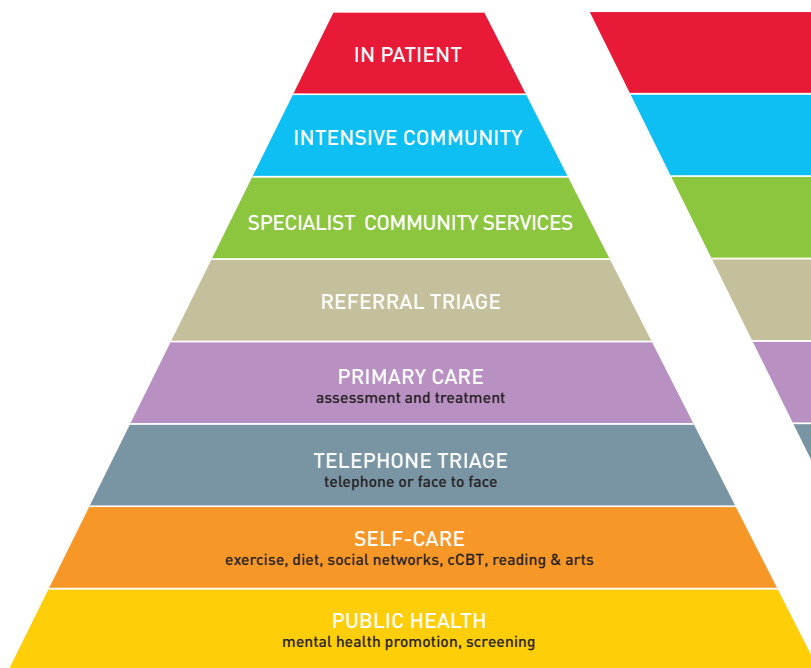


Figure 1

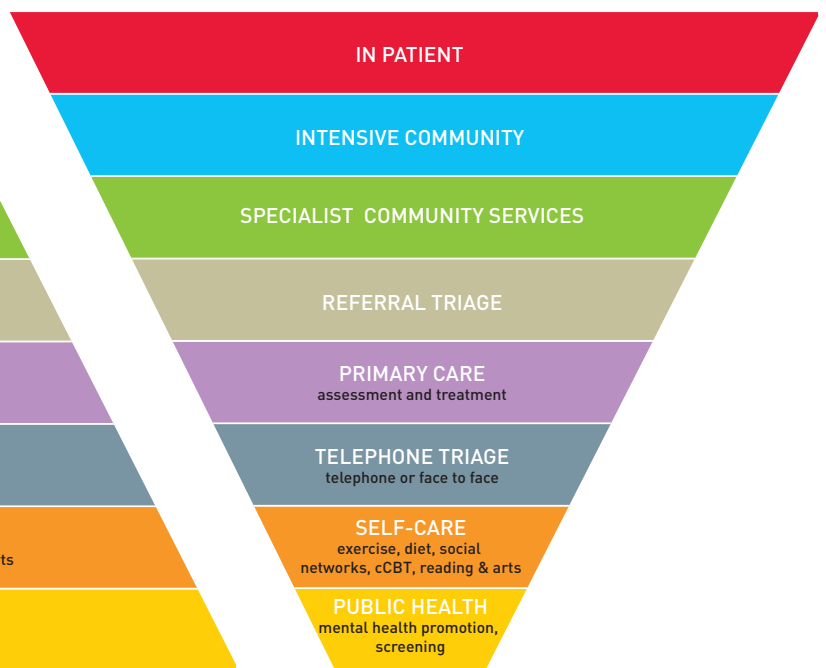


Figure 2

The lack of appropriate specialist skills and resources for support at the lower tiers means that people tend to become stuck at the top of the pyramid, in the high tariff services. This same lack of appropriate resources means that people who present physical symptoms that obscure an underlying mental problem continue to be referred to physical health specialists. The consequence is impaired health outcomes for individuals and significant cost inefficiencies for the health system as a whole.

A more integrated approach to healthcare delivery would turn the pyramid on its head (fig 2 above), and put significant focus and resourcing for mental health into both public health and primary care.

Going public

Public health professionals play a pivotal role in the commissioning and delivery of integrated mental health interventions. Needs assessment at both population and individual level is integral to the achievement of good outcomes. It should provide evidence-based information on prevalence/incidence, effectiveness and cost effectiveness, and the outcomes of existing services. When done jointly with local authorities as part of the statutory Joint Strategic Needs Assessment, needs assessment becomes a critical tool in identifying opportunities for disinvestment, resource transfer and informing the Local Area Agreement process.

Interventions at population level can help promote public awareness, reduce stigma, and provide information about self-help measures. There is a substantial evidence base for interventions at this level, collated by the Association of Public Health Observatories¹² and by NIHC public health intervention guidance^{12, 13, 14}. Such interventions are most likely to be led at a strategic level by public health professionals working through Local Strategic Partnerships. But their implementation will depend on focused activity by a range of wider community organisations, including Environment, Leisure, Crime and Disorder Partnerships, and faith groups as well as primary care practitioners and third sector community groups.

Primary care

The policy focus is on integrated approaches, early intervention and prevention. So the effectiveness of and user preference for talking-based therapies for common mental health problems, the social inclusion agenda, and the often overwhelming demand management issues within the current secondary care mental health system, make a powerful argument for the development of greater mental health provision within primary care.

Yet much of the necessary resources and expertise in mental healthcare are tied up within secondary care services. And the desire to play a greater role within primary care varies greatly across individual GPs and GP practices. A significant development agenda is called for to address both service initiatives and equity of provision, and also to persuade hearts and minds of the need for change. Practice-based commissioning initiatives and an increased public health profile have the potential to address this, while the Quality and Outcomes Framework provides some opportunities for leverage.

The GP surgery provides the most visible, accessible and least stigmatised entrance to personal health and social care in our society. One consequence of this is that GP practices encounter people with a very wide range of needs – not all of which will be best met through the NHS. Understandably, the medical environment encourages a medical presentation and consequent 'diagnosis' or onward referral, which means there is an inherent risk that emotional distress becomes 'medicalised'. This is not helped by the social stigma surrounding mental ill health, which means that people may not like to admit to their underlying emotional state. Combined with this, a GP's under-developed skills and confidence in identifying and addressing mental health issues may encourage a focus on physical symptoms. Short consultation times and lack of continuity between healthcare professionals compound this risk.



A number of initiatives could improve the quality and efficiency of mental health support in primary care:

- Access to effective advice giving and triage. Early evidence suggests that the use of telephone triage can reduce the number of immediate visits to doctors, does not appear to increase visits to Accident and Emergency departments, and achieves good satisfaction levels from users¹⁶
- Develop appropriate mental health skills for primary care professionals
- Enable flexibility in length of appointments – time is needed to explore mental health issues
- Communication programmes to improve awareness about self help strategies, services and influence professional, patient and carer expectations
- Self management tools for low level mental health problems
- Integrated case management across mental and physical health, targeted at those with the highest levels of need and service utilisation
- Employment support. 'For adults of working age with common mental health problems, the journey towards long-term unemployment and disability often begins in the GP's surgery with the signing of a sickness certificate'¹⁷
- Improved access to psychological or talking therapies. This is now receiving a high level of policy attention and additional funding. However, the evidence of demand for these services from existing service waiting lists and other sources¹⁸ indicates that effective deployment will depend on the ability to identify and target those most in need.

Integrated commissioning

Knowledge is power.
Information is
liberating. Education
is the premise of
progress, in every
society, in every family

KOFI ANNAN



People with mental health needs present and receive services in a range of settings. These include specialist mental health providers, acute hospital trusts, primary care, the voluntary sector, and social care. The rules governing eligibility for care often vary across settings. And the rules governing payment vary too, depending on which funding sources apply. Because mental illness is often long-term in nature, the inconsistencies of the system play out day-to-day, week-to-week, and year-to-year.

For many people, particularly those needing to use services, the current mental health system looks more like a maze than a coordinated system of care. Further, when the system fails to

deliver the right types and combination of care, the results can be disastrous.

A whole system approach looks within and beyond mental health service provision, encompassing the whole range of services and support a person with mental health needs might wish to draw upon, to enable them to live their life to the full.

The Commissioning Friend for Mental Health Services outlines such a system:

- Services are designed to be responsive to the needs of service users and carers
- Stakeholders accept their interdependency and that action by any one of them may affect the whole system

- There is shared agreement amongst all stakeholders on the vision, principles, approach to service delivery, management of performance and review processes
- Those using the services do not experience gaps or duplication
- Relationships and partnerships are enhanced

There is a raft of supporting policy and guidance in the UK that identifies national standards and aspirations for the ongoing modernisation of mental health care, and advocates a shift to more preventative, integrated and inclusive approaches. However, gaps in current arrangements for mental health commissioning have also been well documented (e.g. Audit Commission June 2006) and feedback from service users (e.g. Healthcare Commission 2007) consistently identify significant deficits in current provision.

Current gaps in commissioning arrangements include:

- Significant asymmetry of expertise and power between mental health providers and commissioners in favour of the providers
- Poor quality of information flows
- Absence of PbR framework to date
- High levels of variance between local provider systems (PCT level) in terms of costs and performance against national targets
- High levels of variance often within and certainly between local provider systems on care pathways, thresholds for intervention/admission and models of care
- Relative weakness of national targets as a mechanism for unifying care pathways

To date, integration and joint working has in the main been driven by diagnostic category and/or age. In order to achieve integration in care, both the NHS, Social Care and third sector will have to be bold and innovative in commissioning whole care pathways that cross organisational boundaries. One possible barrier to this exists within the mental

health community itself, if there is an unwillingness to lose the special status it enjoys.

This is wholly understandable because mental health services do face particular challenges and have historically been vulnerable to shifts in investment priorities and to the inherent pull, within commissioning systems, towards the general acute sector. These issues are compounded when services are commissioned in diagnostic silos, against historic baselines which make their effectiveness and efficiency difficult to measure. However, continuing to sequester mental health services ultimately undermines the provision of physical healthcare and disadvantages the provision of mental healthcare. Integrated care and integrated commissioning will work to the advantage of both systems and is essential in improving care for patients. In order to reflect the individual experience and address these deficits, integration needs to span both the commissioning and care delivery systems. Although US integrated organisations are larger than those emerging in the NHS, there are important lessons in the common features of both the integrated systems and network models in the US¹⁹. 'Lessons from America' shines a light on how the most innovative organisations can shape their local system to be:

- Primary care led – reaching in to secondary care
- Medically or clinically led but based on a partnership / collaboration
- Underpinned by robust data management and IT systems
- Focus on chronic disease management – driving individual change at both personal and population level

Integration requires shared collaboration and cooperation between provider and commissioner based on the same objectives and incentives. This can be seen as the fundamental principle behind an integrated commissioning and delivery system that will have direct impact on improving individual and population health.

Information is liberating – what information is required? How much of it is recorded and how quickly can it be accessed? – these are the questions commissioners need answers to.

It is the role of the Commissioner to manage knowledge and assess need²⁰. This requires excellent statistical, variance and data analytical skills. It is therefore imperative that organisations become skilled and competent in order to access the information that will help them achieve better health and well-being, better care, and better value for all.

Who holds the knowledge about service need, models of care and outcomes?

The answer is front line staff, people who access services, community and third sector partners. Commissioners need to engage community partners, clinicians, practitioners, people who have experience of services and the general public. Collaboration with the knowledge holders and local “experts” (by experience and profession) is essential if outcomes are to be optimised.

The work being undertaken to develop a currency for mental health that improves outcomes through packages of care and evidence based care pathways continues to gain momentum under the charge of the national PbR Project Board. Mental health (and learning disabilities) requires a system that incentivises partnership working to optimise outcomes. The best approach being that which centres around the needs of the individual and thereby reduces the risk of unnecessary interventions, or of people being retained too long in treatment.

The payment system for mental health needs to harness the benefits of the approach taken in commissioning care for people with long-term conditions. This will ensure those with severe and enduring mental health care get optimum choices, coordinated care and improved outcomes. A utilisation management (UM) approach has the potential to enable Commissioners to scale self-directed payments, and oversee and monitor personalised packages of care through the use of real time information.

A whole system approach, combined with the recent directive to achieve an integrated delivery system, is fundamental in attaining meaningful and positive change for people who use mental health services.

It may be a complex situation, but World Class Commissioning has the potential to help us find the answers that can lead to a new era in mental health services and a healthier future for all of us.

This discussion paper is episode 1 in the journey from vision to practice.

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