editorials

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Managing change for the better

Impressions of what distinguishes hares from tortoises in implementing the National Service Framework

Over the months since the National Service Framework (NSF) for Mental Health was launched, I have had the privilege of visiting all the mental health services in the Northern and Yorkshire region. Here are some impressions on why some areas are forging ahead improving services and others are not.

'It is up to us'

There is huge variation in the range and quality of services. Whatever the starting point, energy and action to improve things is greatest in those places where professionals and managers have fully realised that the NSF is not prescriptive on how the standards are to be achieved. After years of mental health policy that felt to be too prescriptive to be sensitive to local conditions, there is hope and sometimes even excitement among those who have realised 'it is up to us'.

Where to start?

Concerted action is most evident where the focus is on what concerns the local people most. For many areas this is the parlous state of acute in-patient wards. Patients are bored, lonely or scared. Ward staff are underskilled, stressed and leaving. General practitioners and psychiatrists experience delays in getting their most worrying patients in. And yet this part of the service consumes up to 70% of mental health budgets.

In-patient care has also proved a good place to start because the simplest analysis of the acute ward populations shows that some patients would be better off if they had never been admitted. Around 10% are 'kicking their heels' waiting for community care plans to materialise. That 10% may account for 60% of the total bed occupancy! Sceptics about the alternatives to in-patient care are drawn into discussions about meeting the needs of particular patients who they agree could be better cared for outside hospital. The principles of 'crisis home treatment' and 'assertive outreach', properly applied, become interesting in helping to devise local solutions for local patients.

Getting things right with general psychiatrists

No one doubts that consultant general psychiatrists have a crucial role in delivering the NSF. Service improvement is accelerating where chief executives have recognised that solutions must be found for over-worked unhappy psychiatrists in order to release their time and creative energy (as well as attract new recruits).

The traditional role of the consultant general psychiatrist seems to have become untenable. A high proportion of fixed sessions, together with an increasing demand for a rapid and flexible response to emergency and risk situations, has led to long hours. There is often intense frustration in trying to juggle these two different roles and do either very well.

The solutions are beginning to appear where consultants have felt able to make changes in the way they work, supported and encouraged by the chief executive. Where consultants have been able to delegate a great deal to others in the community mental health team (CMHT) and to ward managers, they have reduced fixed sessions and personal case-loads. Hence, they have more time for the less predictable high-risk patients with complex needs who as a consequence spend less time in acute wards. Some of these consultants even find time to monitor the whole system of care and propose changes to chief executives who are listening. If there were more of them they could take the pressure off consultants practising in a more traditional way with many fixed sessions for therapeutic work and training others.

We cannot afford for new role models for general psychiatrists to flourish in some areas, unknown to others. Consultants are aware of big differences in the way colleagues practise, but not in sufficient detail to be able to learn from each other.

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Primary care mental health

In places where it has been recognised that primary care mental health services cannot be developed without first developing a strategic vision, there is no conflict over where early investment should be to deliver the NSF. Effort is going into developing ideas on the future picture of primary care mental health services not rushing ahead investing in things that may not turn out to be of value.

But some consultants and their teams have found that work on patient pathways into secondary care can progress because there are short term benefits to patients, general practitioners and secondary care professionals. Where general practitioners are referring through a number of channels, to a consultant, psychologist or occupational therapist personally, as well as to the general CMHT, there is great inefficiency. Patients suffer because the chosen portal of entry is often not the right one and there are further delays in getting to the professional best able to help them. Professionals suffer because they waste time assessing and referring on. And renegotiation of the boundary between primary and secondary care is hardly possible because there are too many boundaries and too much complexity.

Where there is a single portal of entry to the CMHT, general practitioners are being persuaded that patients get to the professional they need more quickly. Consultants are not bogged down by work that others are quite capable of doing. Constructive negotiations can take place with practices about better alternatives for some referrals, up to 20% in some areas, who need not come into the secondary care system at all.

Trust restructuring

Uncertainty is demotivating and there is a good deal of it about in whole district trusts and rural mental health services. When will we be restructured? Will it be into a primary care trust that hardly understands specialist mental health care? Or will it be a huge specialist mental health trust, city-based and hardly able to give proper attention to our rural districts? Who will be leading us? The only thing that is sure is that there will be a long drawn-out process, first waiting for the election to be over and second waiting for primary care trusts to become competent candidates for running mental health services.

This problem is being gripped well in places. Recognising that mental health services are essentially local, some trusts are setting out to establish strong leadership of locality services approximating to the size of a primary care group. This usually means the locality director being invited onto the board of a whole district trust. He or she is encouraged and resourced to develop strategic planning capability separate from the rest of the trust. The resource envelope for mental health services is clearly delineated. Then debilitating uncertainty can be relieved and progress be made on implementing the NSF. Whatever future organisation a locality mental health service may become part of, if the locality director is up to the job, it will join as a confident, competent and well-led organisation without fear of being marginalised again in a primary care trust or a large specialist trust. There are some areas that have gone one step better by appointing the locality director jointly with social services and primary care. Then much of the 'pussy footing' around partnership can be cut through quickly. One able local director delivering service changes for health and social services may save hours and months of partnership negotiation. There is, however, a scarcity of first class managers interested in mental health services.

Research to support service development

There are trusts that have pioneered bringing research to bear directly on their local service problems. Staff welcome research interest in the problems they are tackling. They cooperate by providing better data. They get early results of evaluations of what they are doing, and are encouraged to continue or to review. These trusts are keen to compare outcomes with other services and learn from each other. Such cross site studies can address the vital question of why some services are able to make more rapid progress than others.

Now central NHS research and development (R&D) policy is defining a stream of funding under the heading of 'NHS priorities and needs'. The centre wants to see the service take the lead defining 'what' needs to be done in partnership with local academic departments who can help to define 'how'. Since the solutions often lie in multidisciplinary and multi-agency action, programmes of research will be funded if all the right parties are involved, not least users. There are trusts that are already well into this approach and the effect on morale is striking. Consultants with academic sessions find that the close relationship between their clinical work and this kind of service research can be very stimulating and productive.

One of the top priority areas identified for health services research by the R&D directorate is 'continuity of care'. The *National Listening Exercise* (Fulop, 2000) showed that it is the priority concern of users because it is the depressingly repetitive finding in reports of enquiries into serious incidents. Since there is widespread concern that the Care Programme Approach is not working well, here lie opportunities with prospects of research funding. The topic matters greatly to patients with complex needs and to clinicians who daily experience the difficulties in sustaining programmes of care that involve so many different people.

Levels of confidence

Three things seem to be important in maintaining confidence: realistic optimism that there will be more resources; active planning for increases in staff numbers; and service improvement seen to be taking place now.

With national spending plans promising a 12% increase in funding for mental health services from 2002/2003, leaders who feel challenged to decide how to spend it well are energising staff and changing things

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more than those who are more cautious and pessimistic. This is not like the illusory £21 billion in the last Government spending review. It is a real and substantial increase in funding. The real cause for concern is that the NHS will fail to use it well.

More of the same in increasing staff numbers will not make much difference in quality of services and professional job satisfaction. Roles, responsibilities and skills need to change to meet the enormous changes in clinical presentations and expectations that have overwhelmed us during the past decade.

Reference

FULOP, N. & ALLEN, P. (2000) *National Listening Exercise.* London: NHS Service Delivery and Organization Coordinating Centre.

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