

A new mental health service: high quality and user-led

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For mental health services this is a time of change. We have seen the publication of the National Service Framework (NSF; Department of Health, 1999), a blueprint for mental health care throughout England. By the time this paper appears, the National Plan will have been published – a radical view of the whole National Health Service (NHS) based on consultation with the public and the professions. The National Institute for Clinical Excellence is considering how schizophrenia and depression should be treated, and more mental health topics are on its list. The Commission for Health Improvement – an external inspectorate of clinical governance in local services – has begun its work. A new Mental Health Act is on the way. And, against this background, there is my own appointment as National Director for Mental Health, one of three ‘health czars’, to use the ludicrous shorthand that the press have planted in the public mind.

All these initiatives are directed at a key target in the modern NHS: quality. It is a word that features in numerous public documents on health. It has filtered down into many people’s job descriptions. There is, we often hear, a ‘quality agenda’ as if it were a distinct process – in fact, it runs through everything. So the question is: what do we mean by quality in mental health services? Or, to put it another way, what would a quality service look like?

A quality service would have six elements: it would treat patients and service users with dignity, creating the right environments for them to recover from illness and being guided by their views on how services should develop; it would recognise the skills of families acting as carers, routinely welcoming them into plans of care and responding when they were worried; it would link service activity to need, ensuring that acutely ill people received urgent access to care and that people with a broad range of health and social needs received a comprehensive

package of care; it would make the best and most effective treatments available; it would emphasise the safety of patients themselves – because every year in England there are over 1000 suicides by people currently or recently under mental health care – and also of families, staff and the general public; and it would be delivered by a skilled and motivated workforce.

This, then, is where we should be heading and the means of getting there is the NSF. The NSF, which sets out seven ‘standards’ for mental health care – covering health promotion, primary care, access to services, acute and long-term community care in severe mental illness, services for carers and suicide prevention – has achieved something remarkable. Across the mental health field – a battlefield at times, with diverging views strongly held – it has been welcomed, if not universally then at least widely, and if not without reservation then at least substantially. So the framework is there, and the task is now to turn it into better services on the ground. The NSF is intended to ensure that local services across the country are working towards the same ends: that patients in one area can expect the same care as those in another. But it is a framework, not a prescription, and there is plenty of room for local initiatives.

A crucial part of delivering the NSF will be the monitoring of what local services provide, and this task falls mainly to regional offices for health and social care. Every mental health service has to provide an account of how it is meeting the requirements of the NSF. This ‘local implementation plan’ is checked at regional level according to agreed criteria and all the plans are forwarded to the Department of Health, along with a summary of performance for the whole region. The first local plans had to be submitted by April 2000 and were largely about ‘state of readiness’ rather than actual delivery. They covered organisational issues such as gaps in services as well as aspects of clinical care.

Prominent in the latter were assertive outreach teams, 24-hour access for people on enhanced Care Programme Approach and the availability of secure beds – the Secretary of State’s immediate priorities, known colloquially as the ‘key key’ deliverables because so many things are (single) key. Local implementation plans, known inevitably as LIPs, are rated by regions according to a traffic-light scale of red, amber or green, where red means no plans and in general no go. Only around 10% of all LIPs submitted for April were rated red – a monumental effort had gone into making sure that the NSF was ready to run. It was a promising start and what we now need is a clear, coherent, comprehensive and clinically relevant set of milestones, performance indicators and, ultimately, outcomes to chart the changes in services and their impact on the lives of the people who use them.

What, in all of this, is the role of a National Director? In much of what I do the starting point is the NSF. For example, one task is to make sure that NHS-funded research and development in mental health support the NSF, filling the gaps in what we know and taking successful interventions from clinical trials to real-life practice. I am keen that initiatives in other Government Departments – on drugs or employment, for example – are drawn up with mental health in mind. Overall, I am expected to put forward the view from clinical practice and clinical research. It is not a representative role but it is meant to ensure that when services are developed and policies are made, there is a proper recognition of the reality, the priorities and the failings of clinical care. The task is to bring together the perspectives of patients and users, families and professionals, whose interests are sometimes seen as conflicting but who share the same need for quality.

The concerns of these three groups – the people who deliver the service, the people who use it and their families – were reflected in a statement of personal priorities made a few weeks after I took up my post. All services were asked to bring to an end the practice of admitting people to acute beds outside their local areas. The need to provide genuine 24-hour access for both patients and their families was re-emphasised: the answerphones, unresponsive switchboards or busy on-call staff that we offer at the moment are not enough. I also asked the Royal College of Psychiatrists to give continuing professional development

approval to courses on cultural issues even when these have no direct medical content. I should say that the College did not need to be persuaded about this. I highlighted three clinical areas in which new nursing posts – nurse consultants – might be developed: the treatment of dual-diagnosis patients, acute triage and long-term continuing care. I reaffirmed that the Patient's Charter commitment to single-gender accommodation should equally apply to mental health services. I launched a website for staff, patients and others to tell me their views, and hundreds have already done so.

Along with the opportunities there are also risks. The first of these is that the extra money that is undeniably available to mental health will not make it into the clinical frontline. The total sum is expected to be around £700 million nationally over 3 years, and against an annual bill of £3000 million this is a substantial increase. But health authorities have a history of shunting our money into other priorities, and there are plenty of those, including waiting lists and 'winter pressure'.

The second risk is that clinical staff will be too battered by the pressures that have hit clinical practice in the last decade or so, too worn down by the staff shortages, barren wards and press hostility, too fed up of being asked to mop up the consequences of society's problems of drugs, violence and poverty, and too

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demoralised and defensive to embrace radical change.

What, then, should clinical staff do to ensure that their priorities are reflected in the way the service develops? The question is being considered by a working party of consultants that I set up in May 2000. The working party will report later in the year but it is likely to say that psychiatrists should:

- (a) demand to play a part in the planning of the services in which they work, with dedicated time for those who are most involved in planning;
- (b) ask health authorities to account for the money that has been allocated for mental health – is it being spent on the NSF priorities?
- (c) ensure that mental health gets its share of waiting list and winter money – there are plenty of waiting lists in mental health;
- (d) be prepared to give up some areas of clinical responsibility to support new staffing initiatives, such as nurse consultant posts;

(e) push for specific developments, such as genuine 24-hour access and the abolition of out-of-area acute admissions;

(f) make their views on service development known to the College in order to strengthen its position in representing the profession.

Most of all we need a debate about the role of psychiatrists in a modernised mental health service. What special skills do we have that justify our position as clinical leaders? Which of our current tasks could we shed and who is equipped to take them on? Which new tasks could we adopt? What extra training would we need? What would be the impact on clinical responsibility and responsible medical officer (RMO) status of changes in our clinical role? The College can lead this debate and the results could fundamentally reshape our profession.

REFERENCE

Department of Health (1999) *The National Service Framework for Mental Health. Modern Standards and Service Models*. London: Department of Health.