

## **Modes of Commissioning Expanded Psychological Treatment Services and Related Incentives**

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1. The overall cost benefits of offering people on Incapacity Benefit access to cognitive behavioural therapy and other interventions to enable them to return to work are described elsewhere<sup>1</sup> (accepting that provision of the clinical intervention by itself is unlikely to be sufficient, and that some form of pathway of engagement needs to be developed between the health and benefits and employment systems).
2. Pilot Centres have now been established in two locations to test those conclusions in practice, but if they are successful it would be necessary to see the development of a national network of, say, 250 such centres to fulfil the potential of the initiative. This paper examines possible commissioning mechanisms and incentives to support such an expansion over a period of ten or so years, and their likelihood of success in the context of the prevailing structures and priorities of the NHS. To do that it is assumed that as a result of the initiative there will be:-
  - (i) long term savings in the Incapacity Benefit budget as significant numbers of people with common mental health problems move off Incapacity Benefit into paid employment, and also the numbers of people in employment moving onto Incapacity Benefit are reduced, and
  - (ii) in the shorter term, increased costs of healthcare provision to deliver the intervention (and associated pathways to work) albeit in the longer term there might result an overall improvement in the health status of the population and also a reduction in health inequalities.
3. The following problems arise:-
  - (i) how do you direct resources to a 'new priority' in health when there is relatively limited 'provider pull' to drive its adoption uniformly across the health system (unlike, for example, elective surgery)? CBT is a relatively new technology, where there is a national shortage of suitably skilled practitioners. Expansion of provision is not principally dependent on the ability to make capital investment and existing providers have other dominant priorities, for example the treatment of the seriously mentally ill in the case of NHS Trusts, or they have a substantial commitment to capital investment in inpatient based treatment in the case of the existing major independent sector providers.

There is also little immediate incentive for health commissioners to address this issue as there is no obvious financial payback for them, there is no strong or significant lobby for services which relate to a group already doubly disadvantaged, and there are many other competing priorities for a pool of resources that is likely to become more constrained over the next few years.

That holds true both at the level of the PCT and practice-based commissioner – for each a deliberate effort would be required to carve out funds currently committed to other forms of intervention, and to reallocate them with no real prospect of long term return in the form of increased resources. The patient group concerned are not consuming significant amounts of GP time at present, nor of secondary mental health care, and so their effective treatment and return to employment would not unlock existing capacity for reallocation, just improve their individual health status. One possible exception to that overall picture is where people assisted by the treatment centre approach use significant amounts of secondary general health care as a direct consequence of their mental health problems, which would reduce if effectively treated. That would create a direct benefit for practice based and PCT commissioners, though it is not clear whether it is the case that the groups of those using secondary general acute service and those on Incapacity Benefit are necessarily the same, and so GPs may be more inclined to use treatment centres for the former in preference to the latter.

Neither should it be underestimated that both mental illness and unemployment remain to some extent, taboo subjects – they are unlikely by themselves to attract the media support that a new treatment for cancer does, or to provoke marches through the streets in their support (if anything, perhaps, they might occur to oppose the opening of new treatment centres).

- (ii) would it be right, as an alternative to efforts to stimulate the redirection of expenditure from within existing health budgets, to transfer money for this purpose directly from Incapacity Benefit budgets to NHS budgets, either at a national level or locally, and where would the incentives rest for that?
- (iii) what would the practical mechanisms for such a transfer be?
- (iv) could we identify a mechanism which allowed the Incapacity Benefit system to commission healthcare interventions directly, outside of any existing healthcare commissioning arrangements, and if we did so, would we compromise the principle of universality of healthcare to a new extent?

#### 4. Solutions

- (i) To redirect existing NHS resources to a 'new priority' in health would require some combination of the institution of an appropriate performance management regime and the creation of commissioner incentives. In practice both systems now co-exist across the range of existing health programmes, but generally when a matter becomes a priority for performance management it is pursued with much more vigour than would result from the creation of financial incentives alone. That is likely to remain the case as long as a vigorous performance management framework exists for the NHS, and it remains true to some extent, irrespective of whether there are additional resources identified associated with the particular performance management priority or not. If it is pursued with sufficient zeal, resources will effectively be re-allocated from other priorities, and conversely if it is not seen as being a sufficiently high priority, even if additional resources are allocated, they are likely to be redirected to those areas which are accorded 'must do' status. That has been borne out by the experience of implementing the NSF for adult mental health. Some priorities were supported by strong performance management arrangements and earmarked additional resources, but there was a tendency for the resources to drift away to support cost pressures elsewhere, until the performance management mechanisms were brought to bear; other, more recent priorities have not had specific resources allocated, but they have nevertheless been implemented, sometimes by attracting funding from other areas which were not accorded the same national status.

Accepting that structural as opposed to performance management incentives may nevertheless have a role, what potential mechanisms are available? A commissioner incentive at practice level could most obviously be developed by extending the Quality and Outcomes Framework for GPs to cover patients on their lists with common mental health problems who are in receipt of Incapacity Benefit. That would encourage GPs either to identify those patients who might benefit from such an intervention through screening, and/or possibly encourage them to refer them on for treatment or possibly to arrange for the provision of treatment within the practice.

There are however problems with many aspects of that approach. It is easiest to use the QOF to stimulate activity within practices themselves and so whilst it might be possible to generate screening activity, it becomes progressively more difficult to create incentives the greater the requirement to refer. Given that there is strong evidence that CBT provided at practice level without adequate supervision arrangements is likely to be ineffective, that would create a problem around the outcome of the intervention,

compounded by the need for a more strategic, rather than practice based approach, to stimulate a comprehensive pattern of provision of centres. Consequently a system of incentives extending beyond level of individual practices would be more likely to succeed, but that would once again be reliant on the degree of performance management effort behind the initiative.

There are in any case, concerns about the QOF amongst PCT commissioners and elsewhere, specifically about the extent to which it has increased the costs of GP remuneration, and the benefits arising from that. Such an approach to incentives would not therefore be likely to command widespread support from PCTs. Initial informal discussions with GPs themselves suggest that the inclusion of CBT for people on Incapacity Benefit within the QOF would be unlikely of itself to generate shifts in their commissioning practice where other established priorities are likely to dominate.

In other words GPs seem to be saying that using the QOF by itself would not work for them as a stimulus to the development of a system of treatment centres. There are no obvious financial incentives for PCTs as commissioners, and so a strong performance management regime will be essential.

A further set of contextual problems whichever approach is adopted are the timing as PCTs undergo major organisational change, we enter a period of transition in payment systems which are by no means clear yet for mental health services, and all this happens against the background of an unusually tight financial situation across the NHS.

- (ii) If attention were turned instead to the transfer of funds from Incapacity Benefit budgets to NHS budgets to offset the reduction in numbers of Incapacity Benefit claimants then, given government will, that would presumably be very easy to achieve at a national level. It would, however, be very difficult to track the effectiveness of any central government transfer at a local level unless, once again, it were accompanied by a clear and tightly drawn performance management framework, and it would also require a degree of pump priming to ensure that the investment went into health before the savings were released in benefits. Of itself this approach would not do anything to stimulate or support the local mechanisms both for the provision of interventions and also managing the pathway into work. It could however have some value in supporting the overall direction.

An approach which transferred funds from one system to the other at a local level would be more likely to encourage development of treatment centres within the NHS (though it is not clear what the response would be at local level in the Benefits Agency) as local managers are more likely to be alert to the reality of the incentives

involved and better able to make the whole system work together at a local level given sufficient will. That would in part depend on the potential for change – i.e. the numbers of people on Incapacity Benefits suffering from common mental health problems, and a realistic assessment of local employment prospects/skills requirements.

- (iii) Some kind of mechanism would need to be adopted for the transfer of funds from one agency to another at a local level, and examples of these have now been in operation for some time – usually between health and social care. The most recent and the most wide ranging is the Local Area Agreement. This builds on the local authority responsibility to promote well being in their communities (and it is understood that West Sussex County Council and NHS are considering just such an approach in order to enable people with common mental health problems to get back into employment). So far however it has not been tested, Local Area Agreements are still to be rolled out around the country, and the evidence from an initial evaluation<sup>ii</sup> suggests that the NHS has sometimes had difficulty engaging in LAAs because of the rigidity of its funding structures (back to the performance management regime again) and it is not clear that the DWP has so far been involved in LAAs at all. If such a mechanism were to be adopted it would need the attention and leadership of the relevant local authority and so this programme would need to become a key issue for them. It might be recognised as part of their overall responsibility for the well being of the communities they serve but it runs the risk that such an initiative becomes dependent on local authority interest when they are neither one of the prime beneficiaries nor one of the principal agents.
- (iv) The use of a Local Area Agreement mechanism or alternatively an even more radical arrangement whereby healthcare interventions were to be directly commissioned by the Benefits Agency, would raise the prospect of drawing resources for direct health intervention for a limited group of people from outside the NHS. So, in that sense, it would breach the principle of the universality of healthcare.

To what extent though, does that principle already hold absolutely in practice? By the identification of any specific priorities within healthcare (which tend only to affect a sub-set of the population because of the difficulty of directly comparing different sorts of health needs) we alter in practice the extent to which some parts of the population have their needs met relative to others. There are also now many instances where pooled budgets have been established for the provision of health and most commonly social care, but where in fact the availability of resources from outside the NHS has a direct impact on the extent to which healthcare is available in a given locality. This is most generally true in the case

of pooled budgets with social care for mental health, learning disabilities and older people, but there are more specific instances, for example, the ways in which the CAMHS Grant has been directed through local authorities to stimulate the growth of child and adolescent mental health services and the ways in which Drug Action Teams draw on the resources of the National Treatment Agency through an entirely separate commissioning line from other health priorities. In some cases, these very mechanisms have been chosen in order to remedy a situation which has been the result of past neglect.

## 5. Conclusion

No single mechanism of itself guarantees success and the current circumstances in the NHS are rather different from those which have prevailed over the last five years, so it would be a mistake to assume that the same mechanisms would work again in the same way, and we should be cautious about drawing too literally on examples from National Service Frameworks.

Most likely to succeed however would be a specific allocation made at national level by the Department of Health, performance managed through commissioners combined with strategic priority accorded to the need to develop a pattern of provision, irrespective of whether that is by the NHS, independent or voluntary sector or a mixture of all three. That should be combined with an associated workforce development plan, reflected in the commissioning of CBT training, possibly through the developing network of centres themselves, and the building of links at a local level with the employment service, possibly under the aegis of local authorities through LAAs.

Direct incentivisation of GPs at a local level alone would be unlikely to achieve any of that in the current climate except in a very ad hoc manner, and may itself prove controversial as a mechanism given the concerns over the impact of the QOF.

To the extent that ideal approach cannot be guaranteed then some form of transfer of funding from the benefits system itself becomes more attractive (though perhaps not to the DWP). It offers the only practical means of unlocking resources to support the necessary investment within a reasonable timescale for payback (see i above) and may, therefore, be the least dependent on some form of external pump priming. It would benefit from some kind of strategic priority, and recognition being given to DWP both for reduction in the numbers on Incapacity Benefit and the outcomes for them in terms of increased employment opportunities and improved mental well being.

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<sup>i</sup> Implementing the NICE guidelines: a cost-benefit analysis – R.Layard; D. Clark; M. Knapp; G.Mayraz

<sup>ii</sup> Evaluation of Local Area Agreements by Office for Public Management for ODPM