



editorials

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The NHS Plan: 2 years on

When the NHS Plan (Department of Health, 2000a) was unveiled in July 2000 it was heralded as promising a step change in the modernisation of the NHS in England. In fact mental health, as one of the Government's leading clinical priority areas, had already been the focus of considerable policy development. *Modernising Mental Health Services* (Department of Health, 1998) had set out a vision of services that would be 'safe', 'sound' and 'supportive' (with the policy emphasis firmly on the 'safe'). It was followed by the publication of a mental health National Service Framework (NSF; Department of Health, 1999), revised and simplified, if highly prescriptive, guidelines for the Care Programme Approach (Department of Health, 2000b) and a White Paper on reforming the Mental Health Act (Secretary for State & Home Secretary, 2000).

By the time the NHS Plan appeared a structure had already been put in place by the Department of Health to performance manage implementation of the mental health NSF – the local implementation team. In 2001 there were 126 local implementation teams, each representing a local health economy. Crucially the NHS Plan included a number of specific pledges for mental health service development by 2004, based on what later became a promised additional £300 million recurrent revenue (see Box 1). The first tranche of this revenue was hypothecated, that is, ring-fenced for the purposes set out in the NHS Plan.

Box 1. 'What the National Plan will create'

1000 new graduate mental health staff working in primary care
 500 additional community mental health workers at the 'gateway' between primary and secondary care
 50 early intervention teams
 335 crisis resolution/home treatment teams
 220 additional assertive outreach teams; women only day services
 700 extra staff to work with carers
 Accommodation for 400 people moving out of high security
 Improved services for prisoners with mental illness, both within prison and on release

(Source: Department of Health, 2001a)

Local implementation teams have been required to report on their progress in the implementation of the mental health NSF, the NHS Plan and a variety of other policy targets (for example, implementation of the recommendations of *Safer Services* (Appleby *et al*, 2001)). A cycle of self-assessment by local implementation teams of local implementation plans and feedback against a range of performance indicators, using a traffic-light system, enters its fourth iteration during 2002–2003. As part of this process data to enable the production of a detailed map of provision across England were collected in the Autumn of 2000 and, using more refined methodology, in 2001. Access to this Domesday book will be of enormous interest to practitioners and researchers.

The mental health policy implementation guide

A key text in understanding the modernisation agenda for mental health services is the policy implementation guide (Department of Health, 2001b). Published in a loose-leaf binder (and available on the internet at <http://www.doh.gov.uk/pdfs/mentalhealthimplographics.pdf>) it is intentionally a work in progress. The policy implementation guide envisages 'whole systems change', in line with the philosophy of modernisation. The initial version set out in some detail service specifications for three key components of secondary mental health care: crisis resolution/home treatment teams; assertive outreach teams; and early intervention services. In addition it included somewhat looser discussions about primary care mental health (which has clear commitments within the NHS Plan) and mental health promotion (enshrined within Standard one of the mental health NSF). Improving primary care mental health services along the lines envisaged within the mental health NSF by, for example, developing robust referral protocols that include advice on first-line treatment, might considerably decrease the burden on secondary mental health care.

The core sections of the policy implementation guide have an academic apparatus that provides justification for the proposed service developments. The plans have strong face validity, but may be criticised for going beyond the available evidence, as of course did the mental health NSF (NHS Centre for Reviews and



Box 2. 'Changes in organisational and care culture that are required to achieve the modernisation agenda'

Increased partnerships and reduced hierarchy
 Increased choice and autonomy for service users and carers
 Increased transparency – both for service planning and clinical care
 Increased value on evidence-based services
 Increased focus on outcomes, as opposed to inputs and outputs
 Increase in integrated and mainstream services and reduced specialisation and service insularity
 Increased value on information systems
 Increased attention to supporting the workforce, both clinical and management
 Increased value placed on non-professional and volunteer staff
 Increased opportunities for involvement of staff groups in major redevelopments
 Increased meaningful service user and carer involvement and inclusion in service planning

(Source: Department of Health, 2001b)

Dissemination, 2001). The primary implementation guide also includes a chapter on tailoring services to local needs. It features a lengthy list of 'changes in organisational and care culture that are required to achieve the modernisation agenda' (pp. 86–87). This merits particularly close reading as a guide to overarching Department of Health priorities, and maps on to issues evaluated by the Commission for Health Improvement in their clinical governance reviews (see Box 2).

Essentially the policy implementation guide envisages a functionally differentiated service system within which multiple specialist teams (primary care liaison, crisis resolution, assertive outreach and early onset) provide care to people referred for specialist mental health care, along the lines of the model developed in North Birmingham. This model can be seen as contrasting starkly with the current standard model of provision in England: the generic community mental health team (CMHT), which may or may not be able to refer on to services offering rehabilitation and continuing care. Crucially the policy implementation guide included a statement that: 'It is not intended that where good services are in place, like well-functioning community mental health teams, that these services should be abandoned. New investment in these new functionalised teams will help overburdened in-patient and community services' (p. 6).

After the policy implementation guide

A number of further initiatives have taken place post the policy implementation guide. Work has been undertaken on areas identified as priorities in it but lacking clear statements of how services should develop (women's services, services for people with personality disorder, dual diagnosis services, support to carers and links with the criminal justice system). A draft document on the CMHT was circulated for comment on an extremely tight

time scale and definitive advice about the role and staffing of the CMHT that can be added to the policy implementation guide is to be published. A National Institute for Mental Health in England is being developed (Department of Health, 2001c). This as yet somewhat sketchy organisation is to be led by the National Director for Mental Health (Professor Louis Appleby), and will include regionally-based mental health development centres, a national mental health research network and a series of time-limited development programmes.

The National Director has ensured that local implementation teams are required to have consultant advisers whose dual remit is to advise the team about implementation of the mental health NSF and NHS Plan and to ensure that consultant colleagues are engaged in the agenda for modernisation of mental health services. The President of the Royal College of Psychiatrists and the National Director jointly convened the first of a proposed series of meetings of consultant advisers in February 2002. Advisers have subsequently been offered additional training in change management.

Progress to date

Despite quite modest investment to date, most of which in the first year went to the burgeoning medium and low secure sector, the mental health NSF and NHS Plan have already led to rapid and quite profound system change. The most notable achievement has been in catalysing the integration of health and social services (a goal that had eluded the best efforts of policy makers for almost 30 years). Dialogue between primary and secondary care has been facilitated by the mental health NSF targets for primary mental health care.

The 2002 Budget confirmed that the NHS is to receive unprecedented growth monies over the next 5 years. This suggests that the ambitions expressed for mental health services in the mental health NSF and NHS Plan can be achieved. However, only modest additional funds were available during 2002–2003 to meet these ambitions (with more promised next year). Local implementation teams have had to prioritise essential service developments, following guidance from their performance managers, and the Modernisation Board was able to report that about 170 assertive outreach teams had been set up (Department of Health, 2002). Anecdotally, some local implementation teams have chosen to invest in the new services at the expense of existing CMHTs, while others have engaged in service redesign and have been able to maintain or even further invest in the core work of the CMHT. There is a real danger that those services choosing to disinvest in the CMHT will experience catastrophic failure at a time when expectations are running high, unless startling and immediate benefits accrue from the new services mandated by the policy implementation guide.

One further concern, underlined by consultant advisers, is the issue of workforce. All the money promised to the NHS will come to nothing if we cannot recruit staff to carry out the tasks required by the



thoroughly modernised, radically redesigned health service. It is highly likely that this new service will require more trained psychiatrists, even with clever redesign of professional tasks and roles. Perhaps the National Director could expend some energy unblocking the expansion of senior house officer training posts in psychiatry.

Declaration of interest

None.

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What is the future of the psychiatry of learning disability?†

Two surveys about learning disability service organisation and psychiatric staffing appear in this issue. Smiley *et al* (2002, this issue) had a 100% response from Scottish service providers to their survey looking at the relationship between psychiatric staffing levels, other resources and catchment area sizes. They found that services that had completed their resettlement programmes had the highest staffing ratios. In a survey of consultants in four English regions, Alexander *et al* (2002, this issue) had 67 (71%) responses, the majority of whom were satisfied with their jobs, despite being dissatisfied about the limited extent to which they had been consulted about management-led service reconfigurations. These consultants had a large measure of agreement about the focus of their clinical work being with people with learning disabilities who also have mental illness or behavioural problems. In addition, more than half thought that learning disability services should include people with high-functioning autism, and a third thought that they should include people with cognitive impairment resulting from head injury. This is particularly interesting following Carpenter's opinion in the February *Bulletin* (2002) that psychiatry of learning disability should encompass these groups and evolve into a new speciality of neurodevelopmental psychiatry.

The future of the psychiatry of learning disability has been the subject of lively debate since Professor Joan Bicknell's appointment to St George's Hospital Medical School in 1980. The same fundamental challenge remains now as it did then – to be clinically relevant and not just concerned with service delivery models. Bicknell's brief from the South Thames Regional Health Authority was to redefine the contribution of doctors to the health care needs of people with learning disabilities. Her

appointment followed the conclusion of the Normansfield Inquiry (Department of Health, 1978) into appalling conditions in a mental handicap hospital that, nevertheless, had had a distinguished early history. The report of the inquiry heavily criticised the medical superintendent.

Specialists in mental handicap have always been members of the Royal College of Psychiatrists and have had a prominent position within the College, but at that time this was as a separate speciality from mental illness. The service model was primarily a custodial one. Joan Bicknell's vision of learning disability as a psychiatric speciality aroused considerable anxiety and mistrust at the College, and perhaps this was understandable given the slow pace of long-stay hospital closure and the prominent role of mental handicap consultants within them. However, during the 1980s a number of psychiatric specialities were delineated, the psychiatry of learning disability gradually clarified its own position as primarily a community-based psychiatric speciality and the move away from separate health care for people with learning disabilities began to gain momentum.

In the early 1990s the Mental Handicap Section had a ballot on a change of name and the majority voted for psychiatry of learning disability. I recall proposing psychiatry of disability as one option and 11 others voted with me. The name of the Academic Department at St George's Hospital Medical School had already been changed from Psychiatry of Mental Handicap to Psychiatry of Disability. Our idea had been to explore the similarities and differences in the phenomenology of mental illness for people with learning disabilities, deaf people and people with sensory disabilities, head injury or autism. We were interested in the clinical relevance of mental health issues for all disabled people. Our proximity

†See pp. 299–301 and pp. 302–304 this issue.