Resource allocation in mental health

A **Discussion Paper** from The Centre for Welfare Reform on behalf of the Care Pathways and Packages Project Programme Board and the Yorkshire and Humber Mental Health Leadership Group.

Simon Duffy | 25th October

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Introduction

In Yorkshire & Humber local leaders have been working together to develop a coherent approach to promoting personalisation in mental health services. The first phase of this work culminated in the publication of *Personalisation in Mental Health* (Duffy, 2010).

This document set out a template for promoting personalisation across the region and provided a set of initial challenges for local leaders to resolve. One of the most important of these challenges was how to develop a resource allocation system which could enable the use of individual budgets and other funding arrangements that promote increased personalisation.

On 20th July 2010 a group of leading practitioners came together to begin the process of thinking through how resource allocation in mental health would be best developed. There are no simple or easy solutions to this problem, but the group decided that the most promising approach would be to use and adapt the existing methodology for funding in mental health which has been developed by the Care Pathways & Packages Project (CPPP) to enable the development of a Payments by Results Approach (PBR).

Following this discussion South West Yorkshire Partnership Foundation Trust (SWYPFT), Kirklees Primary Care Trust and Kirklees Council offered to pilot the development of an integrated Resource Allocation System (RAS). It is now an urgent local priority to test the feasibility of this approach and other areas are showing interest in exploring this approach. This paper outlines the initial thinking that underpins this local decision to innovate.

1. Background

1.1 The birth of the RAS

Resource Allocation Systems (RAS) are important to personalisation because they provide a set of rules that allow professionals to make fair, open and reasonable judgements about what funding is appropriate to meet someone's needs. This information can also be used to give someone an individual budget before they begin to plan their support and this increases creativity and flexibility. These funding systems are also useful for other systems of individual funding (e.g. vouchers, grants, lead professional budgets etc.)

The first RAS was developed by Duffy in 2003 and then further developed by Duffy & Waters for In Control (Duffy, 2005). Local authorities and the NHS can all develop their own individual systems, but most have continued to use the Duffy-Waters approach. The recent national template, developed under the leadership of the Association of Directors of Adult Social Services (ADASS) used this same methodology.

There has also been a general tendency to try and find one approach which will work reasonably well for all groups supported by adult social care, in particular:

- Older People
- People with physical disabilities
- People with learning difficulties, and
- People with mental health problems

Developing one RAS is not without its difficulties. There are two primary problems. First there has been a tendency to treat the same needs differently within different service areas, e.g. there may be higher expectations for people with disabilities about how much they can contribute to society, as opposed to older people, and this may lead to higher allocations. In addition prices may also differ between service areas, e.g. care for someone with a learning difficulty may be charged at a premium compared to care for someone who is older.

In general there has been an understandable effort by local and national leaders to develop 'one RAS' (at least at a local level) for people using adult social care. This approach would seem to be more equitable and, in the long-run, more efficient.

1.2 Payment by Results

The NHS has only recently begun to consider how to embrace personalisation and there is still much to learn. But there are many existing threads of work within the NHS and mental health services in particular, which while they were not developed to promote personalisation directly, may be able to support its development. One of the most important of these initiatives is the Care Pathways & Packages Project (CPPP).

The CPPP approach has been developed over several years by a mixed group of expert practitioners in mental health. It tries to define an appropriate level of resource (and best practice pathways) for individuals with particular patterns of need. In effect it is a Resource Allocation System by a different name - although its initial purpose was not to provide individual budgets there seems no reason in principle why it could not be adapted for this purpose.

As set out in Figure 1 all Resource Allocation Systems are essentially a set of rules which link eligible needs to an appropriate level of funding. These rules should be underpinned by principles of equity and social justice and needs should be defined in terms of desirable outcomes. The system developed by CPPP seems to be well suited to being redefined as a Resource Allocation System.

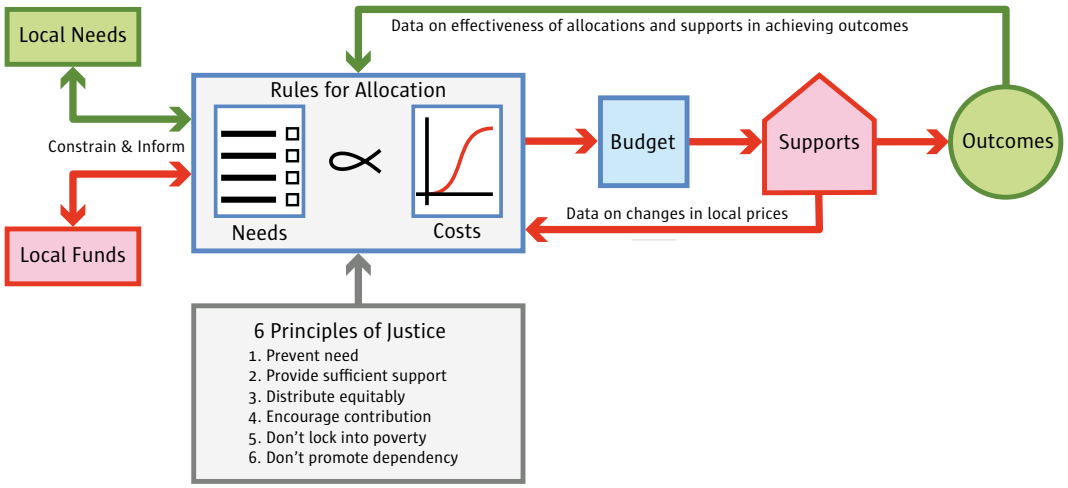

Figure 1 Resource Allocation Systems

1.3 Personal Health Budgets

There are also several new initiatives, many in Yorkshire & Humber, that aim to develop Personal Health Budgets (individual budgets for health care). However, much of this work seems to be modelled on the earlier work in adult social care. This seems to have led to the application of the Duffy-Waters RAS within a health care context. However it may worth local leaders pausing before taking this step. The Duffy-Waters approach is very specifically modelled around an understanding of need which is rooted in adult social care practices. It is not obvious that this approach will work well in every health care context.

1.4 Changes to NHS structures

Since the publication of *Personalisation in Mental Health* one further factor now needs to be considered which is the plan to radically change the commissioning structures within the NHS (DoH, 2010). In essence the basic policy direction seems to be to:

- Minimise the use of specialist NHS commissioning
- Maximise the use of General Practitioners as commissioners
- Promote a greater role for local government in providing leadership in public health matters

Although there is little understanding of what this means for mental health specifically there is no doubt that any future strategy will need to be particularly sensitive to these changes. Arguably there is also an increased opportunity for promoting further integration in mental health services by increasing the strategic leadership role for local government, the front-line leadership of General Practitioners and by giving mental health service providers the opportunity to lead the development of personalised and innovative supports.

2. An integrated RAS for mental health

Yorkshire & Humber has committed itself to the development of an integrated resource allocation framework for mental health, and this is for a good reason. Mental health services and supports are currently funded by a combination of local authority and NHS spending. Local authority funding is for 'social care' and NHS funding for 'health care' - but many doubt whether this distinction is very helpful to people with mental health problems or to the professionals who work in this complex and fragmented system. An integrated approach would offer several advantages:

- People would only need to face one assessment for resources
- There would be less bureaucracy and transactional waste
- Services would be integrated around one plan and one funding stream
- It would fit better with an integrated Care Programme Approach (CPA)
- It would be clearer for professionals

2.1 The need for integration

Although an integrated approach is highly attractive it is also worth noting that, in principle at least, it is also possible to have more than one system of resource allocation and even to have multiple systems of assessment, planning and accountability running in parallel. In fact many people managing individual budgets today find that they may in fact have to manage multiple funding and bureaucratic relationships. For instance some individuals are now receiving funding from:

- Adult social care
- NHS - continuing care funding
- Independent Living Fund
- Learning & Skills Council
- Supporting People

But while multiple funding streams and resource allocation systems are possible they do seem particularly unattractive and unhelpful - especially when funding is really being used for broadly similar purposes.

The need to pursue integrate in mental health is particularly acute because:

- People in mental distress do not need greater complexity, burdens and confusion
- Policy has continued, rightly, to encourage one integrated approach
- Mental ill health is a clear, coherent and substantial need which can not be usefully separated into health and social components
- The health-social care distinction relies upon a distinction in processes or services which cannot be sustained when the focus shifts to improving outcomes by the most appropriate and effective means

2.2 The options for integration

In *Personalisation in Mental Health* we argued that there were at least four options for integration:

1. Do nothing - keep two different systems
2. Link the two systems - keep two systems, but find trigger points and other mechanisms for linking and simplifying the system
3. Integrate the system, but not the funding - develop one system, but find ways of determining distinct NHS and LA elements of funding
4. Fully integrate the system - develop one system and use a system of pooled funding in order to run the one system

2.3 Full integration using the CPPP approach

However in the regional workshop we quickly reached the conclusion that now was the time to focus on option 4 - full integration. Our reasons for this decision flowed from considering these technical options in the light of current realities. In particular it struck as important to recognise:

1. Direct local authority funding (less than £2 billion in England), while important, is not comparable with NHS spending on mental health (at least £18 billion in England). It seems unlikely that the application of the 'one Adult Social Care RAS' is going to be successfully tuned to the needs of people with mental health needs when the vast majority of the relevant funding will be coming from elsewhere. In fact this may help explain why some local commissioners are finding either that their RAS significantly over-provides to people with mental health needs, while

others are finding it significantly under-provides. This could be the result of trying to tune a system to needs which are largely going to be met from elsewhere (the NHS) - not from local authority funds.

2. Any realistic approach to promoting personalisation in mental health will depend upon finding a model which has significant support from within the mental health professions. Early work in developing the adult social care RAS was based upon close consultation with social workers and care managers. However in mental health there are other professional groups that must be considered. The current CPPP approach is based upon multi-disciplinary understandings of need and well validated measures of cost. This model seems well placed to offer the best way forward.
3. Although there are some different points of emphasis between the Duffy-Waters model and the current CPPP approach both offer broadly similar accounts of risk and need. It may well be possible that the CPPP approach might benefit from further adaptation and development. However instead of developing a different system, linked to adult social care, it would seem more sensible to develop a joint approach which builds on and develops the CPPP approach.
4. In Yorkshire & Humber there is growing interest in the use the Recovery Star for mental health as a shared account of the desired outcomes across mental health services. Given that this framework provides some of the balance and more 'social' perspective that local authority leaders are keen to support then this would seem a better tool for ensuring that the focus of mental heath services was sufficiently holistic and positive.
5. While local authorities only have a limited *direct* role in funding mental health services they have wider responsibilities, powers and resources that promote increased mental health through community development and increased well-being. It is unhelpful for current NHS spending on mental health to be dislocated from the broader social factors that underpin mental health, it is for this reason that the current strategy set out in *New Horizons* (HMG, 2010) encourages a preventative approach to improve mental health - an approach that can only succeed with local authority leadership. It is for the same reasons that *Personalisation in Mental Health* encouraged local leaders to use Total Place Commissioning in order to make the best shared use of resources (see Figure 2). The use of one shared RAS, making transparent the current use of resources in mental health could be a powerful tool for promoting prevention.

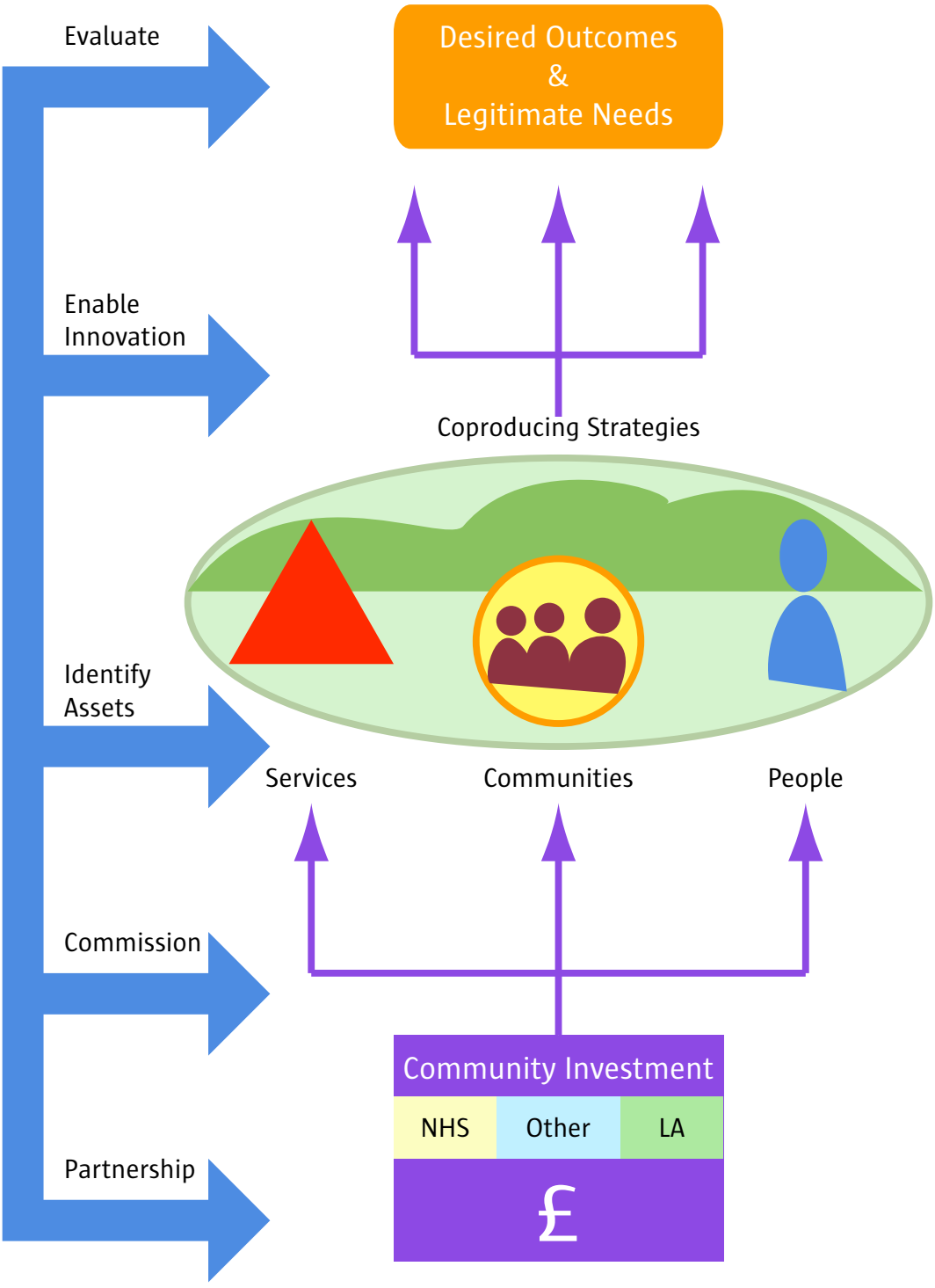

Figure 2. Total Place Commissioning

3. Challenges

Of course the difficulties that we will face are significant. We can list several:

- The joint approach will need to be lifted out of the complexity of Fair Access to Care Services (FACS) eligibility and current means-testing systems - but given the dominance of NHS funding (>90%) this seem feasible.
- There will need to be a broad strategic agreement as to the level of local authority funding included in the overall system and the balance of risk and liabilities. Increasingly this will need to be done in partnership with General Practitioners and the new commissioning arrangements. However, while this will certainly increase short-term complexity it will also increase the incentives for all concerned to revisit the on-going funding for mental health services.
- The CPPP approach takes account of all cost - but individual budgets normally exclude those elements which are not controllable - work will need to be done to think through some of the operational and technical issues this raises. Effectively mental health providers will need to develop some of the provider-led models for personalisation like Individual Service Funds (ISFs) that have been described in *Personalised Support* (Fitzpatrick, 2010).
- Responsibilities to families also need to be considered - local authorities and the NHS have tended to think about family support in different ways and there are still general uncertainties about how to make personalisation more family-focused. However this is also an important area for increased collaboration and understanding if families are going to be better supported.
- The CPPP approach, which was to underpin Payment by Results, may be slightly different in its methodology than the adult social care when it comes to cost control - however this can be tested out within any early piloting. It is vital that the design of the new system promotes cost efficiency and cost control and these factors are be built into the new system.

There are also some reasons to think that now is a very good time to try this more ambitious approach:

- Central government will probably continue to support personalisation for some time to come.
- Central government will back strategies that seem to reduce bureaucracy.
- Central government is increasingly open to tackling policy obstacles that are associated with the previous government (e.g. FACS).

- Changes in the NHS are likely to promote a stronger role for local government.
- Strategies for increased cost control and increased efficiency will be at a premium

4. Next steps

There is growing interest in the approach outlined in this paper and a clear commitment from Kirklees to test feasibility as soon as possible. With this commitment further thought will need to be given to the following steps.

4.1 Pilot the integrated approach

It will be important to model how the existing CPPP data, which is extensive and detailed, could be used to build a personalised approach to funding. Ideally there would be some very early piloting, using the CPPP as a RAS for a small group of individuals.

4.2 Publish the approach

Once any initial problems had been solved the model could be published and shared regionally and nationally. The current status of CPPP as the hub of national work on PBR adds credibility to this project and will help the distribution of any learning.

4.3 Develop shared governance

As an integrated approach it will be important that NHS and local authority colleagues agree to work together and co-author the RAS. The overall funding commitment into a shared pot would also need to be agreed at a senior level. It may be useful to look at how the current CPPP governance structures can serve the new arrangements.

Conclusion

It is not possible to overestimate the importance of these issues. Although the development of Resource Allocation Systems can seem technical and irrelevant to broad policy objectives, nothing is further from the truth.

The creation of this new approach will creates new dilemmas and new opportunities for leaders in mental health services. It is our view that if we allow two distinct allocation systems to develop for people with mental health services then we will have actually made the current system worse - not better - because we will have added complexity, inefficiency and incoherence to the current system.

On the other hand, if we commit ourselves to a genuinely integrated approach we could take a real step forward, not just in promoting personalisation, but in developing real integration and partnership between the NHS and local government. This will involve confronting, rather than avoiding problems, but it will lead to a share understanding of need and entitlement.

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Acknowledgements

This paper was written by Simon Duffy on behalf of the Personalisation in Mental Health Steering Group. Special thanks to all those who attended the workshop upon whose discussion this paper is based: **Stuart Davis**, **Carole Green**, **Leigh Halton**, **Clare Hyde**, **Alistair Penman**, **Ian Smith**, **Steve Stericker**, **Angie Walker**.

Publishing information

First published September 2010
ISBN download: 978-1-907790-08-9
14 pp.

Resource Allocation in Mental Health is published by The Centre for Welfare Reform on behalf of the Care Pathways & Packages Project Programme Board and the Yorkshire & Humber Mental Health Leadership Group.

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Parkway Business Park
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S9 4WG

The publication is free to download from:
www.centreforwelfarereform.org

Published by The Centre for Welfare Reform
www.centreforwelfarereform.org

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