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# What general practitioner fundholders want to buy from a psychiatric service

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The Government White Paper 'Working for Patients' (1989) incorporated the idea of general practitioners (GPs) managing funds in order to purchase health services for the patients under their care. The aim was for decisions about purchasing and providing health care to be taken as close to the patient as possible, by their own GP. It has meant that two forms of purchasing have grown side by side – health authority and GP fundholding. Subsequent policy changes have made fundholding accessible to more practices, and have extended the fundholders' areas of purchasing. More than 50% of the population in England are now covered by fundholding GPs. The proportion of GPs who are fundholders varies enormously geographically, with high levels in the West Midlands, Trent, South Thames, Oxford and Anglia regions, where the collective purchasing function of GP fundholders is now very considerable.

I will look at what, and how, GP fundholders purchase; at the changes that are occurring as a result of GP purchasing; and at GP fundholders' issues with current mental health services, and how they want to see them relate to primary care. Lastly, suggestions will be made about areas that a consultant psychiatrist can address with their local GP fundholders, which will impact on their purchasing. I will focus on adult services, although the purchasing of services for the elderly and for children and adolescents is also of great concern to GP fundholders.

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## What GP fundholders purchase

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Budgets allocated to standard GP fundholders continue to cover the purchasing of hospital and

community services, medication and the employment of practice staff. Also, they receive a management allowance and part of their computer costs.

In the area of mental health care, this year has seen the extension of GP purchasing to include NHS day care in addition to those areas previously purchased, that is, out-patient care and consultant domiciliary visits, community mental health team (CMHT) services, direct access therapies (e.g. clinical psychology), and in-house psychological therapies. Thus, few areas of psychiatric care (i.e. in-patient care, or hostel care provided by mental health services; specialised services, at regional or supra-regional level; emergency referrals; social services care; self-referrals; and voluntary services, excepting those agencies that have a provider code) are left outside the GP purchasing remit.

The Total Purchasing pilot schemes, in which GPs purchase all NHS services, are now under review, with the possibility of their further extension.

Mental health service changes are impacting GP fundholders' purchasing, as the GP's role extends to those patients now resettled in the community from long-stay hospitals. Some GPs are concerned about the extra workload involved with these changes, and it is well documented that a large proportion (up to 40%) of patients with schizophrenia lose contact with psychiatrists and are seen only by their GP (Pantellis *et al*, 1988; Kendrick *et al*, 1994).

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## How GP fundholders purchase

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In the acute sector it is relatively easy to define procedures, and to cost them. This is more difficult in community services, where contracting is still

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only in its third year. Initially, community money was ring-fenced – all to be spent in the NHS, with GP fundholders' over- and under-spending being absorbed by the regional health authority. Last year this ceased to be so in the area of mental health. Currently, GP fundholders use a variety of contracts and currencies for mental health services (Box 1).

Block contracts offer the greatest financial certainty for both parties, especially in this early stage of contract development. However, the currencies used have major drawbacks. The number of 'contacts' tells the GP nothing of the needs level of the patient, the clinical relevance of care given, or its outcome, the time the contact represents, or who sees the patient ('CPN' being generic for any CMHT worker). In many areas the quality of data on reported activity is poor. In addition, the counting of contacts is seen as a frustrating, time-consuming irrelevance to the majority of professionals required to do it, adding nothing to their care of the patient. Thus, GP fundholders are left not knowing what exactly they are purchasing. Contracts will also have specifications on the quality of services being provided (e.g. communication required, Care Program Approach use, etc.).

#### Box 1. Currencies of purchase of mental health services by GP fundholders

*Cost per case* – used for specialised services. The actual cost of treating an individual patient is charged. Different sub-specialities, and first and subsequent visits, are costed differently

*Community block contracts* – usually cover the NHS component of CMHT costs (currency unit = 'CPN contacts'), psychotherapy and child guidance. May also include out-patients (currency unit = 'attendances'). This contract is based on reported activity for the practice in the previous year. Psychiatric day care is also being contracted for as a block, in this its first year of purchasing by GP fundholders

*Cost and volume* – for a basic block contract the GP fundholder pays a set amount throughout the year, regardless of volume of work, but in a cost and volume contract, specific volume limits are set, beyond which a cost per case charge is made

## Effects of GP purchasing

There has been much discussion about the power that purchasers hold to bring about change and increase the effectiveness of health care through the contracts they make, although McKee & Clarke (1995) challenge this. To date, fundholding has had less impact on psychiatric services than on general surgical and medical care. GP fundholders have largely been repeat purchasers of existing services, rather than commissioners of services they wish to see develop. Various factors have contributed to this. First, mental health services are complex, hard to understand and contract for, and difficult to monitor – due both to the block contracts, and the poor quality of many data. Second, GPs have usually felt that they have no real choice of provider for the care of the severely mentally ill, since their multiple-agency needs necessitate local, coordinated provision of care. There is concern not to destabilise local services.

In reality, there has rarely been significant input by GPs on the strategic issues, such as hospital closures and reprovisions; CMHT configurations; the inter-relationship of NHS mental health services with social services; and speciality service provision. Strategy for mental health services has remained largely the property of health authorities; and where they have not developed comprehensive mental health strategies, provider trusts have, by default, become the strategic planners.

## 'A primary care-led NHS'

This situation is changing, fuelled by several factors. First, recent government publications have emphasised the need for purchasing to be led by primary health care (NHS Management Executive, 1994, 1995). Mental health care now represents a very significant proportion of a GP fundholder's care budget, and is a growing area which GP fundholders recognise that they must come to grips with, if the quality of services is to be improved and budgets controlled.

A second very significant change has been the rapid growth of the GP fundholder consortia, such as the multifunds, which give GP fundholders the power and support of coordination in their local area, as well as expertise in areas such as contracting, quality control, finance and information systems. There are now some 50

multifunds in the UK, covering approximately three million patients, and represented nationally by the Association of Independent Multifunds. Such organisations are beginning to develop as commissioning as well as purchasing agencies in regard to mental health services. For example, the Kingston and Richmond Multifund, with 170 GP fundholders, last year developed a pilot system for patient-focused contracting for services for those with learning disabilities. That led to the setting up of a mental health project within the Multifund, which reviewed the existing provision of mental health care, the GP fundholders views on it, and the financial structures and current system of contracting.

Third, Shapiro (1996) notes the change in professional culture, with GP fundholders moving from shorter-term purchasing to more thoughtful, longer-term relationships with their providers and health authorities.

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## Relationship between primary and secondary care

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The issues and concerns regarding mental health services that affect GP fundholder purchasing (arising from the Kingston & Richmond Multifund (1996) study) are given in Box 2.

Cumella *et al* (1996), in their survey of the commissioning process for mental health services in 20 health districts in England and Wales, noted the impact of local GP fundholders' purchasing on services; in particular, a shift to practice-based catchment populations, contracting for more specific referrals, and the development of practice-based mental health teams. Kendrick (1994), reporting on GP fundholder aims for mental health services, notes their desire for freedom of referral; direct access to CPNs; and provision of counselling and other psychiatric services on site. The Kingston and Richmond Multifund survey also found certain areas that GP fundholders felt to be of importance in their purchasing intentions, and many of these overlap with these earlier studies' findings.

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### *CPN's relationship to the practice*

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The vast majority of GPs would prefer a CPN directly attached to their practice. Some used the term 'liaison CPN', others 'attached CPN'. The majority wanted a CPN who will:

- (a) be a liaison point with the CMHT and other secondary services;
- (b) have regular contact and communication with the primary health care team;
- (c) be the keyworker for patients in that practice (unless there are particular reasons for another worker to be); and
- (d) have a role in other aspects of care (e.g. overseeing lithium monitoring) and in the continuing education of practice nurses in psychiatric care.

Some GPs wanted a CPN who would be based in the practice, see patients directly in-house, and to some extent be integrated into the primary health care team while still being part of the CMHT. A smaller number talked of contracting with a CPN directly, outside of the secondary care system, so establishing a practice-based mental health team with the psychological therapists already in-house. This last point is obviously controversial in terms of the cohesion of services from multiple agencies for the severely mentally ill, and preventing fragmentation of care. However, it reflects the frustration of some GPs with the care received by their patients and therefore a desire for managerial control over the CPN's input and time. This is now a possibility for GP fundholders, and in a few places has been acted on. It demands a serious response from CMHTs to pre-empt this by improving collaborative working.

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### *Practice alignment of CMHTs*

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GP fundholders were dissatisfied with:

- (a) having to relate to more than one CMHT;
- (b) inadequate regular contact with the team(s);
- (c) not knowing who is under the CMHT's care; and
- (d) the inadequate provision of social work input to the mentally ill in primary care.

One of the reasons for sectorisation rather than practice alignment is the issue of coterminosity with social services boundaries. A second is the geographical area of some practices, crossing health authority boundaries for in-patient care. These are serious issues in the practices to which they apply, and local solutions will have to be sought. However there are many practices which will not be affected by them. Corney (1984) pointed out the role for attached social workers in general practice, and many GPs would like a liaison social worker from the CMHT, similar to the liaison CPN.

### Box 2. Purchasing issues for GP fundholders

*Commissioning and purchasing issues* – volatility of need makes budgetary planning, especially in smaller practices, very difficult. Some specialist services are both very expensive and geographically inaccessible, and GPs would prefer to contract for local provision. The increasing workload in caring for the relocated severely mentally ill in the community needs reflecting in benefits to practices. Commissioning and purchasing do not focus enough on joint GP fundholder/provider planning.

*Acute and crisis response* – for GPs the need for a quick, effective response by mental health services in an emergency (24 hours) is paramount, and was rated by the GP fundholders as the most important area of secondary care (see also Strathdee, 1990). Access to the consultant (not the senior house officer) for crisis advice, and single access phone numbers for crisis services were desired. Particular problems arise where patients have dual diagnoses (e.g. learning disability and acute psychiatric problems, or substance misuse with another diagnosis) where often neither service may want to accept them in crisis.

*CMHT issues* – the ongoing care of the severely mentally ill was rated as the second most important aspect of services purchased. Where CMHTs are not GP aligned, relating to more than one team is difficult. Shared lists of the severely mentally ill by practice are needed, as GPs may not be aware of patients being seen by the CMHT. GP involvement in care programme reviews depends on these being at a time and place reasonable for the GP. Management of situations where a CMHT considers a referral inappropriate for them need discussion with the GP concerned.

*CMHT-GP liaison and the CPN role* – the role of the CPN is often still not clear. Some were said by GPs to see patients with neurotic disorders, others only to see the severely mentally ill. The attached CPN should be keyworker to practice patients wherever possible, to improve communication with the practice. Also, GPs would like input into the choice of CPN assigned to them.

*Communication and information* – poor feedback on care, and the difficulty of access to senior medical staff are issues, GPs feeling they usually have to initiate any contact. The need for more accurate data for planning and purchasing, and for access to basic patient data through shared information systems between GPs, providers and social services are noted.

*Out-patients* – consultants often continue to see patients regularly in remission, when the GP is also seeing them; at times GPs need to request a patient's discharge. Lack of communication, of shared care, and of continuity of doctors in out-patient departments contribute to this. Long waiting lists for certain services prompt changes in contracts.

*In-patient care* – insufficient beds (hospital, hostel and group home), with too-high hospital bed efficiencies, are felt to lead to premature discharge and subsequent re-admissions. The combining of alcohol and drug detoxification beds on wards with severely mentally ill patients is of concern. Local beds are desired. Poor, delayed communication and documentation from in-patient units make subsequent patient management more difficult for the GP.

*Staffing issues* – these especially relate to staff providing in-house services often not being replaced if on maternity/other long leave; and the disastrous effects of locum consultants, especially if multiple, to a CMHT and its patients.

### ***Freedom of referral and alternative consultant availability***

This is obviously a difficult issue because of the critical need for local, integrated care for severely mentally ill patients. Most GPs accept this

dilemma, but feel there are patients who can travel for services needed, and resent the lack of access to a consultant of choice that sectorisation may imply, or even enforce. They want a clear policy in place with providers for situations where a relationship between a patient and their local consultant breaks down.

## Clarification of roles between the CMHT and the practice

Despite some mixed feelings about CMHT-practice agreements, there was positive response to the clarity that an agreement could bring to communication, CPN involvement in the practice, joint planning of care, audit of the relationship, etc.

## In-house psychological therapies

Budgets for in-house psychological therapies are a growing area. In the Kingston & Richmond Multifund study, 60% of practices had in-house counsellors, and 75% have in-house counselling or psychology, or both. More than 50% of the counsellors were employed privately, with costs to the practice of up to 50% less than if they employed through a Trust. Areas of concern raised by the Multifund study were:

- (a) patients with minor psychiatric morbidity are a large and time-consuming group in primary care; the increased emphasis on the severely mentally ill by secondary services means that the boundary of GP responsibility for these patients by GPs has been extended, and GPs therefore need to extend their own in-house services, which is often not financially possible for small practices;
- (b) the spend on in-house psychological therapies is now beginning to affect purchasing of other areas of services, particularly direct access psychology, but potentially other areas also;
- (c) despite widespread appreciation, both by patients and GPs, for in-house counselling, its clinical effectiveness is not clear;
- (d) levels of qualification and supervision of counsellors vary greatly; and
- (e) targeting of particular types of patients for counselling or clinical psychological intervention is inadequate.

A whole new area of mental health care has grown up in the UK with the advent of practice-based counselling. This has happened in an *ad hoc* way, and is now very widespread. A recent review of NHS psychotherapy services (NHS Executive, 1996) highlights the lack of evidence of clinical effectiveness of primary care counselling to date, and emphasises the importance of counsellor qualifications, the referral of appropriate patients, and the use of focused interventions. With some notable exceptions, providers have not been proactive in responding to this new area of services in a systematic and cost-competitive way, so

leaving much of the provision to individual private counsellors. While this may be adequate in many cases, Trust-provided counsellors can offer GPs the surety of vetted qualifications, supervision, and the inclusion of their patients in a tiered system of care where needed.

## Discussion

GPs and psychiatrists share many concerns over the provision of mental health care, and many of the strategic challenges faced in providing effective mental health services are the same. However, the emphases in primary and secondary care will differ, since the patterns of mental health problems seen, the time-frames of contact and care, and patient expectations and responses differ. Most GPs have not worked in psychiatry, nor most psychiatrists in primary care, and the issues and priorities of each require mutual understanding. Without this, GPs' priorities for mental health services, and those of the secondary services may, and probably will, conflict. For example, prioritising the care of the severely mentally ill by CMHTs could conflict with the needs of the more numerous, less severely mentally ill seen by GPs. As the Clinical Standards Advisory Group (1995) pointed out, good services for the severely mentally ill require GP fundholders also to prioritise this group in their contracting. The Review of Mental Health Nursing (Department of Health, 1994) and Gournay & Brooking (1994) both concluded on the need for CPNs to focus on the severely mentally ill; again, this needs the agreement of GP fundholders.

GPs are a heterogeneous group, differing widely in their recognition rates of psychiatric disorder, in their referral rates of those identified, in their expectations from referral (a single consultation for advice, or ongoing care), and in their desire to manage their psychiatric patients themselves. In addition, local public health information on needs assessment for practices varies, as does the level of cooperation between GP fundholders and their local health authority. All of these factors will affect purchasing of secondary care.

How, then, is an individual psychiatrist, or Trust, to understand what a particular GP fundholder or consortium may wish to buy? Even, to have some influence in shaping their purchasing intentions and strategy? The following could be an initial list of areas for psychiatrists to consider in the practical relationship with their local GP fundholders.

## *Relationships and communication*

The reasons for lack of understanding between primary care and psychiatry have been recorded by Horder (1988). These must be addressed between GP fundholders and providers in order to achieve a longer-term relationship which can benefit both parties – not simply to give short-term advantages on a particular contract. Locally:

- (a) does the provider have a structure for regular communication between consultants, managers and its GP fundholders – are there GP user forums in place with the Trust?;
- (b) is there management and clinician commitment to this process, with committed time given to the interaction, and to understanding the differing viewpoints and cultures between GPs and provider Trusts?;
- (c) is there a system for addressing areas of conflict and difficulty – where specific difficulties arise, does the consultant or another team member contact the GP directly?; and
- (d) how frequent is personal contact between consultants and GPs?

## *Clinical care development and audit*

Is there:

- (a) practical application of ‘shared care’, and guidelines in place for this (e.g. referral and discharge protocols)?;
- (b) does each CMHT and consultant regularly review cases held, and consider patients’ transfer back to primary care – is the decision discussed with the GP?; and
- (c) is there a ‘one stop shop’ entry point into emergency and crisis services, with agreed timescales for a response?

## *CMHT–practice relationships*

Locally, have the following been implemented, or alternatives discussed, between psychiatrists and GP fundholders?:

- (a) practice-aligned CMHTs;
- (b) clear agreements on the responsibilities of CMHT staff to the practice, the frequency of meetings or communication, and ongoing audit of the working relationship;
- (c) regular CMHT–primary care team joint meetings in the larger practices;
- (d) shared registers of the severely mentally ill under CMHT care updated at those meetings,

with responsibility for maintaining the register allocated, probably to the liaison CPN;

- (e) Care Programme Approach reviews coordinated with joint meetings, or timing of reviews coordinated with the GP; and
- (f) need for an effective model for small practices where joint meetings may be unfeasible.

## *Liaison worker role*

Does each practice have:

- (a) an assigned liaison CPN, with a named liaison CMHT social worker also;
- (b) regular meetings of that CPN with the GP/primary care team; and
- (c) a high percentage of practice patients key-worked by the liaison CPN, with this being regularly monitored.

## *Policies for availability of alternative clinician*

Have local solutions for this been sought and developed? For example, ‘twinning’ of CMHTs so that if a second consultant is required, at least only one other team is involved.

## *In-house psychological therapies*

Locally, are there:

- (a) referral guidelines for GPs for Trust-provided counsellors; and
- (b) pro-active dialogue with GP fundholders about their counsellor requirements, and a Trust commitment to developing this aspect of services.

## *Information and data*

As purchasers, GP fundholders need clear and accurate information around which to make decisions.

- (a) Does the Trust provide a Directory of services, with key clinical and management names given? Is there a system for up-dating GP fundholders on Trust issues?
- (b) For an individual patient, does the feedback to the GP include a clear plan for patient management and a stated expectation of the GP’s role, for example, prescribing, information giving, carer support, suicide/ violence risk assessment?

- (c) Is the Trust's information system able to provide a GP fundholder with an accurate list of the number of their patients currently in care, giving diagnoses, the care given, and the outcomes?
- (d) Is there review of data with GP fundholders?

### Continued post-graduate education

Are there opportunities sought for clinicians to offer ongoing post-graduate education sessions to local GPs?

## Conclusion

Few dispute the critical nature of the GP's primary therapeutic role in the further development of good mental health care; or the vital need for collaboration between agencies in the care of the severely mentally ill (Department of Health, 1995). However, with the advent of fundholding, GP fundholders now also have a pivotal role in influencing and driving the direction of secondary care development through their commissioning and purchasing. Although the form of fundholding may change with time, this role is likely to remain. As psychiatrists we have the opportunity to influence this direction through pro-active dialogue with GPs, increased mutual understanding of the issues involved, and through partnership in planning and implementation (see Box 3).

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### Box 3. Good practice points

Good communication  
 'Shared care'  
 Regular review of need for ongoing care  
 'One stop' access in crisis  
 Practice-aligned CMHTs  
 Shared registers of the severely mentally ill  
 Liaison CPN for every practice  
 Alternative consultant policy  
 Referral guidelines for counsellors  
 Good information and data  
 GP post-graduate education

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## Multiple choice questions

- The following services are usually included in community block contracts:
  - in-house psychology and counselling
  - community mental health teams
  - forensic services
  - out-patient care
  - psychotherapy.
- The majority of GP fundholders would prefer a CPN:
  - to be a liaison point with the CMHT
  - to provide in-house counselling to the mildly mentally ill
  - to be part of the CMHT
  - not to key-work patients in the practice
  - to have regular contact with the primary care team.

3. The contract currency of 'CPN contacts':
- a specifies time commitment involved
  - b does not tell the GP the clinical relevance of care given
  - c clarifies the needs level of the patient
  - d is clinically helpful to the community mental health team worker
  - e does not give any outcome information.

## MCQ answers

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|-----|-----|-----|
| 1   | 2   | 3   |
| a F | a T | a F |
| b T | b T | b T |
| c F | c T | c F |
| d F | d F | d F |
| e T | e T | e T |