

**BECOMING WORLD
CLASS COMMISSIONERS
OF PRIMARY CARE
MENTAL HEALTH
SERVICES:**

*A review of current
commissioning in
Manchester*

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CONTENTS

PAGE NUMBER

1.	Introduction	3
2.	Scope of the review	4
3.	Methodology	6
4.	Assessing the needs of the patient population and managing the health care system	7
5.	Planning services to meet needs	9
6.	Prioritising investment, stimulating the market and Tendering for new services	13
7.	Managing contracts and performance monitoring	14
8.	Making sound financial investments and Demonstrating value for money	16
9.	Engage with the public, partners and collaborate with clinicians	17
10.	Promote improvement and innovation	18
11.	Conclusions and recommendations	18
12.	Implementations of the recommendations	20
13.	Next Steps	23
	Appendix A: Membership of the Primary Care Mental Health Services Oversight Group	24
	Appendix B: Bibliography	25
	Appendix C: Overview of Needs Assessment Projects in Manchester since 2003	29
	Appendix D: Mental Health Pool Investment In Primary Care Services 2008/09	30
	Appendix E: Scoping of Interpretations Services In Manchester	31

1. INTRODUCTION

This is a report to outline the results of a review, of how Primary Care Mental Health Services are commissioned and provided across the City of Manchester.

The review was initiated by the Joint Commissioning Team (JCT) within Manchester Primary Care Trust. This team has responsibility for commissioning Mental Health Services, within Manchester, on behalf of Manchester Primary Care Trust (PCT) and Manchester City Council (MCC). There is a pooled budgetary approach to the commissioning of Adult Mental Health services with a Section 31 agreement. It is recognised that the future commissioning of these services will move to the Practice Based Commissioning Boards. However, this is complicated by the current Section 31 arrangements between the PCT and Local Authority.

The review has been overseen by a strategic group of commissioners, operational managers, local authority, clinicians and representatives of the Practice Based Commissioning Boards, within Central and South Manchester. This group agreed the Terms of Reference and Scope of the review. Membership of the group can be seen in Appendix A. The review commenced in December 2007, and was completed in May 2008.

The intention of this report is not to duplicate areas already reviewed in previous needs assessments and their accompanying reports, most notably, the Strategic Review of Mental Health Services in Manchester, by the Health and Social Care Advisory Services (HASCAS, 2006). Nor is the review intended as a comprehensive needs or gap analysis within Primary Care Mental Health Services.

In addition, this review did not focus on the performance or contract monitoring of the Primary Care Mental Health Teams (PCMHTs) or services. If the reviewers had any concerns about aspects of performance management it was agreed these would be managed out-with the review, on an individual team/service basis.

2. SCOPE OF THE REVIEW

To review the commissioning arrangements of the Primary Care Mental Health Services within Manchester.

The anticipated outcomes of the review were:

- a) The development of consistent Care Pathways
- b) The development of core standards of service provision
- c) The identification of any unmet needs
- d) The development of up to date Service Specifications and Service contracts.

THE COMMISSIONING CYCLE

The Joint Commissioning Team is responsible for commissioning all of its services, adopting the Commissioning Cycle. Briefly, this is a systematic process of:

- Assessing the needs of the patient population
- Planning what services are required to meet these needs
- Setting priorities and allocating resources
- Tendering for new services, so that service providers are able to compete to provide health and social care services
- Developing contracts and detailed service specifications for the provider organisations, which have been successful at tendering for services.

Providers can be from the statutory (public), independent (private), voluntary and third-sector (not for profit organisations) or social firms.

- Undertaking thorough and regular reviews of the contract, to ensure service users are getting the service which has been commissioned. This is also an opportunity for service providers and commissioners to work in partnership, to identify any unmet needs that the patient population may have.
- Undertake more comprehensive reviews of the service provision, either annually or as determined in the contract.
- Demonstrating value for money, i.e., that the services provided, are the most clinically and organisationally effective services which the allocated amount of funding can purchase.
- Commissioners can achieve this through benchmarking with other commissioners, regionally, nationally and internationally, by comparing unit costs (the costs of assessments / treatments/ therapy etc) and the outcomes of service provision, with each other.

- Involving people who use the services, and members of the public in most of the stages of the above cycle is vital and also a statutory requirement, under Section 11 of the Health and Social Care Act (2001).

WORLD CLASS COMMISSIONING

World Class Commissioning was introduced by the Department of Health (DH) in December 2007. It is essentially, a vision, guidance and framework for ensuring PCTs achieve excellence within commissioning, transforming people's health and well-being outcomes at a local level. It is also about reducing health inequalities and promoting social inclusion (Department of Health, 2007).

The guidance for World Class Commissioning also includes 11 sets of competencies for all commissioners to achieve. These are the knowledge, skills, behaviours and characteristics which underpin effective commissioning. They are outlined below:

- Locally lead the NHS
- Work with community partners
- Engage with the public and partners
- Collaborate with clinicians
- Manage knowledge and assess needs
- Prioritise investment
- Stimulate the market
- Promote improvement and innovation
- Secure procurement skills
- Manage the local health system
- Make sound financial investments

This review draws upon both the commissioning cycle and world class commissioning, to assess how commissioners have developed Primary Care Mental Health Services, across the City of Manchester. The scope and outcomes of the review are therefore located within these frameworks.

3. METHODOLOGY

A range of methods were utilised to collect information from the eight services, which are currently commissioned to provide Primary Care Mental Health Services.

Briefly, these included quantitative data collection, such as structured questionnaires, service activity figures and qualitative methods, for example, semi-structured interviews, with members of staff and other stake-holders, including commissioners from the JCT.

Site visits to all of the provider services were undertaken, to initially meet with the Service or Team Managers and then with other members of staff. The planned site visits to 42nd Street, did not occur and were not re-arranged within the time period available. Throughout the process of collecting data, every member of staff was extremely helpful, by sharing their knowledge, experience and expertise as well as key documents, pertaining to their service.

The commissioned Primary Care Mental Health Services all provide services for people from the age of 16 upwards, except for 42nd Street, which focuses on the needs of young people.

The providers are:

Manchester Community Health, provide three Primary Care Mental Health Teams, across the City, referred to as:

- North PCMHT
- South PCMHT
- Central PCMHT.

- 42nd Street, who specifically provide a range of services for young people
- Self-Help Services, provide guided self-help, primary care mental health services and computerised Cognitive Behavioural Therapy (cCBT) across the City, and are based at the Zion Centre, within Central Manchester. Services are provided for those aged 16 upwards.
- The Roby, a third sector provider, which provides a range of services in Longsight, Manchester.
- The African and Caribbean Primary Care Mental Health Team, provide primary care mental health services across the City, for those aged 16 upwards, who identify them-selves as being from an African or Caribbean background. This service is based at the Zion Centre, within Central Manchester.
- Therapeutic Services; provide counselling services, and are part of Big Life Services.

Key Department of Health (DH) policies and guidance, and local documents were also reviewed. (Please see bibliography, Appendix B).

4. ASSESSING THE NEEDS OF THE PATIENT POPULATION AND MANAGING THE HEALTH CARE SYSTEM

Managing the health care system commences with an accurate and up to date understanding of the needs of the population, as a whole, and the patient population specifically.

Without this information, commissioners cannot plan services, effectively in the short or longer-term. The terms of reference for this review did not include a commissioned and comprehensive needs assessment of the patient population within Manchester.

There have been some views expressed by current providers of Primary Care Mental Health Services within Manchester that the outcomes of previous, related studies undertaken within this field; were sufficient to plan services (Please see Appendix C, for an overview of Needs Assessment Projects in Manchester, since 2003; adapted from HASCAS, 2006)

However, the role of commissioners is to now commission for health and well-being, rather than illness- based services (Department of Health, 2007). Work is currently underway on the development of tools which assess mental well-being, rather than signs and symptoms of illness. In Scotland, the Warwick Edinburgh Mental Well-being Scale (WEMWBS) has recently been validated and used. The Care Services Improvement Partnership (CSIP) has proposed a survey is commissioned, using WEMWBS in 2008/9, across the North West.

In addition, Manchester City Council, in partnership with the PCT, is currently undertaking a Joint Needs Assessment (JSNA) across the City. This is a vital element of the commissioning framework for health and well-being (Department of Health, 2007). The results of the JSNA are due to be published by June 2008.

Whilst the results of the above needs assessment and survey, are awaited, what we are aware of; is the change in population trends within Manchester. Briefly, the younger age group (people aged 25-49) is projected to increase from around 34% in 1995 to 40% by 2011. This equates to a rise of around 42, 000 people. This is not in keeping with the population trends of the North West region, where there is expected to be a projected fall within this age group (Bendel, 2007).

Conversely, the projected trends in a growing older adult population (aged over 75), is set to fall by 2009, representing a decline of 4.1%. The number of very elderly people (aged 85 and over) are projected to increase. The projected population within the over 50 age group is also set to fall. Again, these trends are unlike the North West region as a whole, where, for both the over 50s and over 75s the population is projected to increase (Bendel, 2007).

The older working age group (aged 50-64) is projected to remain static, however. Across the North West region, as a whole, this is expected to increase (Bendel, 2007). Life expectancy for both men and women, is expected to increase in Manchester, although a gap between the City and the North West region is still projected, up to 2011 (Bendel, 2007).

What is also known, with respect to Primary Care Mental Health Services nationally, is that over 80% of people with what is described as 'common mental health problems', will receive help, advice, information, therapy and treatment entirely within primary care.

Depression, which is included within this category, has been estimated to be a global health burden by 2020. Another categorisation of common mental health problems, managed within primary care is 'mild to moderate'. However, for those experiencing such mental health problems, that description may be felt to be inadequate in terms of describing the effect that anxiety, phobias, panic disorders and depression can have on their day to day life.

Primary care also provides a service for between 30-50% of people with a psychotic illness. In addition, it has been recognised that those individuals with long-term physical health problems, such as diabetes, and coronary heart disease, are likely to be also at risk of developing depression, in particular. Not only are people with coronary heart disease more likely to have depression, but those with depression will have an increased risk of developing coronary heart disease (Nemeroff et al, 2000).

In terms of stroke, co-morbid depression has been associated with a poorer recovery and functioning (Ormel and Von Korff, 2000).

People with medically unexplained symptoms, being managed within primary care, can account for one in five new consultations (Bridges and Goldberg, 1985). Co-morbid mental health problems are often found in this group of patients, at primary and secondary care level (Reid et al, 2001; Kreonke, 2002).

5. PLANNING SERVICES TO MEET NEEDS

At the commencement of this review, there had been an approximate gap of about six months, since the service specification of the Primary Care Mental Health Service providers had been formally reviewed. The service specifications had not been finalised with the providers and some providers did not have an agreed contract, based on a service specification.

The commissioning deficit in what might be described as ordinarily 'pro-active commissioning' was due to a re-organisation, not only within Manchester PCT, but within the Joint Commissioning Team, itself. The new Head of Mental Health Commissioning, identified Primary Care Mental Health Services, as one of his key priority areas, and thus requested the review to commence in the autumn of 2007. However, due to a number of reasons, the actual review did not commence until December 2007.

Manchester PCT has been in existence since October 2006. Previous to this date, there were three PCTs within Manchester, responsible for commissioning Primary Care Mental Health Services. These were North Manchester PCT, South Manchester PCT and Central Manchester PCT.

These three PCTs had a collaborative commissioning arrangement for mental health services, since their inception.

Each of the previous PCTs had developed their service provision for Primary Care Mental Health Services in different ways. Therefore, access to these services, and choice of service provision, was different for Manchester registered patients, depending on where they lived, or how far they were able or willing to travel across the City.

Inevitably, this has caused inequity for people who need to access these services. Waiting times, to access the statutory services, range from weeks within the North of the City to over 9 months for access to some of the services provided in the South of the City.

Residents within the central part of Manchester have much easier access to a wider range of Primary Care Mental Health Services, as the voluntary and third sector provision is concentrated in the Centre. There are some services which offer outreach, from their main administrative or service base, but this has not been commissioned at a level which could be experienced as equitable for all.

Commissioners and providers have worked to provide services based on needs, which have been identified within locality (i.e., North, Central and South) areas, without any longer-term, city-wide, strategic planning, linked to the whole health and social care economy.

This not only applies to the City of Manchester, but also to the commissioning of these services, by the JCT, from neighbouring areas, such as Trafford, Salford, Stockport, etc, where Manchester registered patients may be receiving mental health care and treatment.

Services, therefore, have grown organically, either through specific commissioning initiatives or through service developments, to meet identified needs. However, even within the three previous PCTs' footprints, the services were not always able to meet the demand for the service, as identified by the waiting lists, within two of the statutory service providers.

In one of the services, the waiting list is managed by the manager writing to the General Practitioners (GPs), and requesting that referrals are not made, until capacity within the team becomes available. When this occurs, support to the GPs is offered in other forms, such as telephone advice.

The ways (or models) in which Primary Care Mental Health Services are provided currently, are based on the stepped-model of care, described in the National Institute for Health and Clinical Excellence (NICE) Guidance for the management of depression in primary and secondary care (NICE, 2004, amended 2007). However, this model does not appear to have been explicitly commissioned within all services.

An adaptation of the Stepped Care Model can be seen below:

Who is responsible for care?	What is the focus?	What do they do?
Step 6: Specialised inpatient care	Forensic history leading to increased risk	Medication, combined treatments, complex psychological interventions
Step 5: Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4: Mental health specialists, including	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3: Primary care team, primary care mental health team	Moderate or severe depression	Medication, psychological interventions, social support
Step 2: Primary care team, primary care mental health worker	Mild Depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1: GP, practice nurse	Recognition	Assessment
Step 0: Public Health, all service providers, local community groups	Mental Health Promotion	Provide self-help literature / brief interventions, health promotion campaigns

Taken and adapted from "The stepped care model": NICE Clinical Guideline 23 (amended), pg 3

Briefly, the aims of this model are to ensure that people receive support and services; easily and appropriately, in the least restrictive manner. The model is also designed to prevent people moving in-inappropriately into services, for those with more complex needs. Each step is representative of increased complexity of intervention.

There is also an assumption that those who receive care and treatment in the higher steps have had interventions in the lower steps. This is not the case-people should enter the most appropriate step for their needs in the stepped care model. This may be interpreted differently across the City.

In theory, within Primary Care Mental Health Services, the majority of people referred should be receiving care in steps 1 to 3.

There is also a compelling argument to include an additional step into this model, step 0, to represent public health interventions and mental/physical health and well-being promotion. Within Manchester, this work has been led by the Public Health Development Service.

Manchester's Local Delivery Plan (LDP), 'Improving Health in Manchester', for 2007/08, will consider a range of business cases, to improve the provision of mental health services within the City. Manchester Public Health Development Service will submit a business case to improve the range of services and interventions available at Step 0 and 1. These will include:

- A 'social prescribing' initiative, to develop access to a broad range of high quality therapeutic alternatives
- A grant fund to permit sustainable development of voluntary and community sector organisations, in their delivery of therapeutic alternatives
- A campaign to open up public appreciation of mental health, as a means of initiating a lasting public dialogue, which will inform the development of primary care services, other services and the impact of key social/economic determinants for public health
- A staff training programme for staff in 'front line' services, in brief interventions for mental health
- Development of a residents' survey tool to measure wellbeing as a key indicator for commissioning

(Inchbold and French, 2008).

The ways in which individuals can refer themselves or be referred into the different steps currently differs across the City. For example, within the North Team, referrals are accepted from GPs, other providers and from individuals' themselves (self-referral). Within the Central Team, GP - only referrals are accepted. The third sector providers accept referrals from GPs, other providers and self-referrals.

All providers should be cross-referring, individuals, if the stepped care model is to work efficiently. For example, for any-one who would benefit from self-help interventions or computerised Cognitive Behaviour Therapy (cCBT), it would be appropriate to refer them to one of the third sector providers.

Similarly, the number of cross referrals to the African and Caribbean Primary Care Mental Health Services is lower than expected. Therefore, there are some resources at steps 2+3 which are not being utilised or explored fully.

Accessing Psychological Therapies, either within primary or secondary care, is also key to the stepped-care model. Within Manchester, two of the statutory PCMHTs have a single point of access for psychological therapies, through the stepped care model. Within the Central Team, any referrals on, to secondary care mental health services, are made through GPs.

Whilst PCMHT staff, within these teams can refer individuals up the steps to Psychological Therapy Services, either directly, or via the GP the reviewers heard, how there was not enough capacity within PCMHS to refer people back down the steps. This meant that the Psychological Therapy services were essentially 'stepping down' patients them-selves, which could not be considered the best usage of their resources.

It was further reported that this also led to Psychological Therapy Services also developing longer waiting lists. Some providers felt that patients on the waiting lists for Psychological Therapy services could have been referred to PCMHS. However, this would also lead to an increase in their waiting list.

The third sector PCMHTs and services do not have a single point of access for Psychological Therapy Services, currently from their services, which again means, that patients have to be referred back to the GP, for onward referral.

This again, creates further inequalities (delays), across the City, in accessing the full range of services available within the stepped care model. It is also not conducive to a stream-lined care pathway for the patient.

It is acknowledged that, seamless working across all of the PCMHTs/Services could be enhanced by the implementation of the Gateway Worker. Within Manchester, the National Health Service target is to have a minimum of 8 Gateway Workers in place.

A business case is currently being developed, as part of Improving Health in Manchester, to secure the additional funding required for 10 Gateway Workers. This role is to strengthen access to specialist mental health services, crisis services as well as ensuring smooth care pathways between primary and secondary care mental health services.

It is anticipated that they will undertake assessments, triage and brief interventions, particularly for those vulnerable individuals, who do not meet the criteria for secondary care mental health services, nor can access PCMHS within the time-frame required.

Taking into account all of the above, the reviewers did not gain a sense that the planning of the commissioned PCMHS, had included any formalised partnership (including cross-referring, joint referral meetings, etc) working between all of commissioned services, to ensure either an equitable or seamless care pathway for patients, across the City.

6. PRIORITISING INVESTMENT, STIMULATING THE MARKET AND TENDERING FOR NEW SERVICES

As already, briefly explained, the prioritising of investment for Primary Care Mental Health Services was undertaken by the three previous PCTs, and the Joint Commissioning Team. Since the inception of Manchester PCT, there has not been any increased investment in these services, other than an additional £70,000 for two Graduate Primary Care Mental Health Workers, as part of a one-year (non-recurrent funding, commencing 2008) waiting list initiative.

These additional monies, were subject to a bidding process by existing PCMHS, and were subsequently secured by Self-Help Services, for the employment of two Graduate Mental Health Workers. It is anticipated these workers will have an impact on the largest waiting list, within the South PCMHS.

The largest investment, across the board, in terms of finance, has been within the statutory services, at steps 2, 3 and 4. These services have not been previously tendered, within a competitive market.

The JCT has stimulated the market by funding services at steps 2 and 3, from a range of third sector providers. Again, these services were not competitively tendered for, and where there has been any growth, this has happened organically (except for the additional £70,000 referred to above).

For the two business cases already referred to, which will be considered as part of Improving Health in Manchester 2008/09, it is anticipated, that, if these are successful, they will be subject to the full tendering process, and will thus stimulate the market further.

The available funding for all of the commissioned PCMHS can be seen in Appendix D. This does not include additional funding, provided by the PCT for the PCMHS within Manchester Community Health.

7. MANAGING CONTRACTS AND MONITORING PERFORMANCE

As previously described, not all of the commissioned PCMHS have ratified contracts in place, based on agreed service specifications. Where there are draft service specifications/contracts, these are not based on the Model Contracts being developed, either within the acute or mental health care sector.

The last review of any of the contracts, in terms of reviewing activity levels, assessing demand and capacity was in early 2007.

The intention of this review was not to undertake detailed contract monitoring, but to gain enough information, to assess how services are commissioned, by the JCT.

All of the services collect activity information, but the quality of the information is variable, in the absence of a comprehensive service specification, quality indicators and outcome measures.

The statutory providers have reported some limitations with their current clinical information system (Lorenzo), in terms of it being fit for the purposes required by the Increasing Access to Psychological Therapies (IaPT) Programme.

One of original aims of this review was to essentially compare or benchmark services, with the aim of developing core standards of service provision. However, the reviewers quickly recognised this would not be possible, as any comparisons between services, operating different models of care, and using different outcome measures, could be considered spurious.

Contract monitoring is also an opportunity for commissioners and service providers to work in partnership with patients or service users, to identify any unmet needs, which the patient population may have.

During the review, meetings were held with the team/service managers and other members of staff, to enable the reviewers to hear about the achievements and challenges each service had.

This was also an opportunity to discuss any areas of 'unmet' need. Without exception, each service described how the needs of patients, who do not meet the current criteria for secondary mental health services cannot be met, within the current configuration of PCMHS.

This group of people has been described by the Sainsbury Centre for Mental Health, as the 'Neglected Majority' (The Sainsbury Centre for Mental Health, 2005).

They are described in the Sainsbury Centre for Mental Health's paper, as having the following characteristics:

“ They have continuing mental health difficulties despite several treatment options from primary care, but do not have a severe and enduring mental health problem as described in the National Service Framework;

Their employment or accommodation is frequently at risk;

Their physical health or other long term condition, is frequently worsened by their mental health problem”

(The Sainsbury Centre for Mental Health, 2005).

The needs of this group of individuals, calls in to question, the description of ‘mild to moderate’ mental health problems, within PCMHS. For the individual them-selves, who may not have responded to the prescribed treatments, as suggested by NICE Guidelines,’ mild to moderate ‘;inadequately describes their levels of distress and disability.

Each service described this group of patients, as having complex health and social care needs, with often, co-morbid physical health needs or substance misuse. The Sainsbury Centre for Mental Health has suggested the creation of intermediate mental health care teams in primary care, to meet the needs of this patient population. This is not to indicate, however, that new or separate teams are developed to meet the needs of this group. In addition this population, is not the same, as those described in the National Service Framework for Older People, as requiring intermediate care (DH, 2001).

The other areas of unmet needs, identified by the teams were:

- Additional services for older adults with mental health needs, especially those within residential and care homes, who are managed by primary care
- The further development of more culturally sensitive services, to meet the needs of all Black and Minority Ethnic Communities, Asylum Seekers and Refugees
- The follow up of people who present with self-harm, in crisis
- Increased and easier access to vocational support, better educational links, housing and welfare rights/benefits advice, for all service users
- Effective translation services, available at no additional cost to all PCMHTS/Services (please see Appendix E)
- Increasing access for younger people, especially those who do not traditionally engage with mental health services
- Increased support for those affected by violence, including guns and knife crime
- Focusing on the needs of younger adults (18 to 25 year old group), who have particular issues in relation to the access of mental health services, most notably around the time of transition to adult services. There are particular

difficulties for people with mild to moderate learning difficulties and mild to moderate mental health problems, refugees and Asylum Seekers within this age group.

In addition, the need for:

- Gateway Workers
- Support Time and Recovery Workers (or support workers)
- Increased GP liaison, and training for GPs in mental health
- Clinical information systems, compatible with the requirements of IaPT, and outcome monitoring
- Increased administration support.

8. MAKING SOUND FINANCIAL INVESTMENTS AND DEMONSTRATING VALUE FOR MONEY

As previously mentioned, all of the PCMHS have grown organically as opposed to the systematic application of the commissioning cycle, by the JCT.

As each of the services has different referral pathways, manage waiting lists differently, and actually provide some of their services in a different way, it was not possible, for the reviewers to determine, at this stage, how sound the financial investments have been within PCMHS. Any financial comparisons on unit costs would have been spurious.

Whilst it may have been possible to calculate a crude unit cost for each session provided by clinicians and practitioners, a comparison between outcomes for individuals, with similar needs, would have to be made.

This was out-with the remit of the review.

9. ENGAGE WITH THE PUBLIC AND PARTNERS AND COLLABORATE WITH CLINICIANS

As part of this review, meetings were held with clinicians, within primary and secondary mental health care, managers, commissioners and other stakeholders, such as Manchester Public Health Development Service.

Two important groups of individuals were not consulted with.

Firstly, a questionnaire was developed, to survey GPs across the City, but the reviewers were advised not to distribute this by the Local Medical Committee. It was felt that GPs had previously made their views clear. Briefly, GPs thought that secondary care services should be providing more support to primary care mental health services, to ensure coverage across the city and to reduce waiting times.

Secondly, the public and people who may have used the PCMHS were not surveyed. During the review, 'Talking Health', Manchester PCT's Programme of Engagement (2008-09) was launched.

The main objectives of Talking Health are to:

- Collate and report evidence about different communities' views and experiences that can be used effectively to inform and improve commissioning decisions. Each household within Manchester will receive a questionnaire this year, covering a range of healthcare areas
- Provide a co-ordinated approach to engaging with local communities on a range of issues during 2008-09
- Achieve genuine engagement with all communities, including those that are harder reach, and develop a strong foundation for ongoing dialogue between the PCT and local people beyond 2008-09
- Promote awareness and understanding of the PCT's role to increase its accountability as the lead NHS organisation in Manchester.

In addition, within the east of the city, the Public Health Development Service is to pilot a residents survey to measure wellbeing as a key indicator for commissioning services.

Taking the above into account, it was felt that an additional survey for PCMHS, would not be appropriate, at this time.

10. PROMOTE IMPROVEMENT AND INNOVATION

The reviewers heard how the promotion of improvement and innovation had largely been led by services themselves, in response to local, unmet needs. Where improvement and innovation had been led or supported by commissioners, this was not part of wider, strategic plans, in relation to the whole health and social care economy.

During late 2007, early 2008, the PCT had to assess its readiness to apply for additional funding, under the national Increasing Access to Psychological Therapies Programme (IaPT). It was clear, that the PCT, based on current service provision was not in a position to bid for funding in 2008/09.

However, work is now being led by the Mental Health Commissioning Manager, for Policy, Strategy and Engagement, to ensure the PCT is ready to bid for funding in 2009/10.

In addition, the JCT is undertaking other strategic reviews, namely; the commissioning review of acute, mental health in-patient care, for Children and Adolescents, Adults and Older Adults. This will be all commissioned provision within the statutory and independent sectors.

Therefore, by March 2009, all Primary and Secondary Mental Health Care, will have been subjected to commissioning reviews, within the last three years (this includes reviews undertaken, as part of the Change in Mind Programme).

This work will inform the development of a Mental Health Prospectus for the City of Manchester, a key requirement of World Class Commissioning.

11. CONCLUSIONS AND RECOMMENDATIONS

This review has focused on how the JCT has commissioned PCMHS across the city of Manchester. There was evidence to suggest, that the commissioning to date, has not reflected the full commissioning cycle, nor the competencies outlined in World Class Commissioning.

- The current providers have not developed their services, in the absence of a commissioning strategy or agreed and ratified service specifications. Contracts, where they exist have not been formally monitored for approximately 12 months.
- There is no evidence that Manchester registered patients have full access to the range of PCMHS currently provided. Care Pathways are not consistent, with differing referral routes and signposting to other services.

- The management of demand and service capacity; has led to a wide variation in the waiting lists across the city, with some patients, waiting for over 9 months.
- There is currently limited capacity within the statutory PCMHS teams, for patients to be stepped-down from secondary care provision, where appropriate.
- There are specific access issues for some patients from Black or Minority Ethnic Communities, including, concerns about the quality of some Interpreter Services (please see Appendix E). Further work needs to be undertaken, to assess the cultural sensitivity of services.
- Core, added value services, such as vocational support, educational links and welfare and benefits advice, need to be available and located city-wide, rather than within individual services. Improved links with the services provided within Manchester City Council need to be made, to ensure best use of available resources.
- Commissioners need to consider how the personalisation agenda will affect the future commissioning of PCMHS; in terms of Direct Payments and Individualised Budgets. This enables the service user to decide which services to procure to best meet his or her needs (currently applies to social care).
- Commissioners should consider having a single point of access to all PCMHS, similar to the Contact Service, provided by Manchester City Council. This would assist with the development of clearer and more accessible Care Pathways. This should also be considered in line with any other plans across the PCT footprint to introduce single points of access to other services.
- Commissioners will need to reflect the outcome of the forthcoming needs assessment of older adults with mental health problems, within its commissioning strategy/plans for PCMHS.
- Commissioners need to also consider the specific issues impacting on the 18-25 year old population, in terms of access, transition into adult services, and continuity of care.
- Commissioners should ensure that the outcomes of previous needs assessments and strategic reviews, including any enquires are reflected in future commissioning plans (Please see Appendix C).
- The engagement of service users, carers and the public to inform the commissioning and monitoring of PCMHS, should be in line with the PCT's 'Talking Health' Programme and the JCT's 'Service User and Carer Involvement Strategy '(2006).

- The commissioning of PCMHS, needs to be coterminous with the commissioning of Primary Care Services across Manchester, in addition to all steps of mental and social healthcare provision.
- Steps 0 and 1, of the stepped-care model need to be strengthened, in line with the proposed business case being developed by the Public Health Development Service.
- The JCT needs to secure funding for the provision of Gateway Workers, as per its target and Policy Implementation Guidance.
- Computerised Cognitive Behaviour Therapy needs to be more widely available and accessible across the City.

12. IMPLEMENTATION OF THE RECOMMENDATIONS

The reviewers propose the following three options for the JCT and its partners to consider, in relation to the conclusions and recommendations above. For each option, there is an expectation that the core components below are a minimum requirement:

Service specifications are developed, to include service standards, demand management, quality indicators, service user and carer engagement and expected outcomes.

The service specifications will include clear care pathways, and cross-referral routes, where applicable.

Revised contracts, based on the national Acute or Mental Health Care Model.

Regular performance management of contracts.

In addition, Commissioners will clearly articulate and set out the commissioning intentions for the future of primary care mental health services. This will be in line with the 10 year Mental Health Commissioning Strategy and the future direction of travel within the health and social care arenas.

❖ **Option 1. Re-negotiate Current Contracts with Providers**

Re-negotiate contracts with current providers, with the minimum requirements outlined above.

The current situation has caused inequalities in access to services and unacceptable waiting times, which is counter therapeutic for service users and frustrating for referrers.

The revised contracts would need to ensure that seamless care pathways and cross-referrals between providers are developed and maintained

This option may not lead to any significant changes in service provision, city-wide. This option does not stimulate the market, in line with world class commissioning.

❖ **Option 2. Mandate a Formal Partnership Arrangement between Current Service Providers**

The JCT would need to develop and re-negotiate contracts and service specifications; based on a partnership arrangement with the current service providers.

The JCT would need to clearly articulate the commissioning intentions, develop a strategy and develop a set of core standards and principles that all providers would be required to sign up to.

This would need to emphasise the need for service re-design, to implement new models of service provision, to ensure that all patients, who require interventions at steps 0, 1 and 2 are referred into the most appropriate services, from referral, and that capacity is developed, to enable patients to be stepped-down, appropriately. This would also ensure consistent standards are maintained across the city.

A single point of access, for PCMHS would need to be included, which would require joint referral meetings between services.

The JCT would need to ensure that a wider range of services were equally accessible to all, to strengthen patient choice.

Formal contract monitoring of the partnership and individual services would need to be undertaken collaboratively, to ensure ownership of the care pathways.

All services would be expected to be outcome focused and would be required to collate a core set of clinical and operational data, in line with IAPT requirements.

The reviewers did not find evidence that the current service providers presently work effectively together, in cross referrals or joint working.

This option would need additional resources in commissioning and providers time, and an agreed period of at least six months would need to be given to providers to embrace and demonstrate the effectiveness of the new ways of working.

This option does not stimulate the market or demonstrate the transparent tendering of services, on an open market.

❖ **Option 3. Tender and Procure a Primary Care Mental Health Service for Manchester**

The JCT would need to develop an over-arching model of service provision, based on the stepped-care model, to ensure service users received support, interventions and treatment, at the most appropriate steps would require detailed scoping across the City.

The JCT would need to ensure that all service users have equality of access to; and choice of, a wide range of services across the City.

This option would clearly stimulate the market and demonstrate that the JCT has embraced all of the competencies within World Class Commissioning.

This option could potentially lead to the de-commissioning of current providers. The JCT would need to ensure the Transfer of Undertakings (Protection of Employment) Regulations 1981, overhauled 2006, are adhered to, for any in-coming employer/partnership or consortium. Due to the complexity of services currently provided (6 commissioned service providers, 8 PCMH teams), this may lead to a period of protracted negotiations.

The JCT would need to consider contingency plans, if option three became the preferred option, as current services may become de-stabilised.

The JCT needs to critically reflect on the outcomes of this commissioning review, to enable commissioning lessons to be learned, so that tendered services are not exposed to the same risks as current providers.

The JCT would need to seek approval from the Joint Commissioning Executive for Mental Health and negotiate with Practice Based Commissioners to consider the future devolvement of commissioning mental health services. The entire budget including the contribution from the pooled budget will need to be agreed before any tender process can commence.

13. NEXT STEPS

- a)** To discuss with Practice Based Commissioning Boards and the Associate Directors of Commissioning within the PCT
- b)** To table at the next Joint Commissioning Executive Meeting, for discussion and agreement of next steps.

Appendix A

Membership of Primary Care Mental Health Services Oversight Group

Craig Harris (Chair)	Mental Health Joint Commissioning Team (JCT)
Linda Colgan	Mental Health JCT
Linda Mason	Mental Health JCT
Elaine Dixon	HARP
Lacey Ingham	Manchester Mental Health & Social Care Trust (MMHSCT)
Tony Ullman	Central PBC Board, Manchester PCT
Joanne Royle	Manchester Community Health
John Butler	Manchester Alliance Community Care
Jeannette Stanley	African Caribbean Mental Health Project
Janet Mantle	Public Health, Manchester PCT
Cath Arnold	South PBC Board, Manchester PCT
Dr. Ceri Dornan	General Practitioner within Special Interest, South PBC Board
Jan Turner	Manchester Community Health
Yvonne Casson	Manchester Community Health
Nicky Lidbetter	Self-Help Services, National Phobic's Society
Pip Cotterill	Manchester City Council

Appendix B

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Appendix C

Overview of Needs Assessment Projects in Manchester since 2003

Needs Assessment	Focus
Children and adolescent mental health. Led by Dr. Latha Hackett, CAMHS Consultant Psychiatrist. Report due Autumn 2005	Needs of children and young people
Mental health needs of under represented groups in Manchester Central PCT, R & D Directorate, MMHSC Trust 2003	Focussed on mild/moderate problems in primary care and undertook a qualitative assessment of the needs of Asian women and attempted suicide and self harm; young men; the Irish Community. Also looked at the GP referral process.
Mental Health needs in Manchester: Led by Liz Thomas, Manchester JCE in partnership with Manchester University and HASCAS. October 2003	Women living in Manchester. Estimates from National data plus detailed views from over 500 women living in Manchester on their needs and preferred style of services provision
Adults of working age in contact with CMHTs in Manchester by Frank Hanily and Dr. Judy Harrison, MHSC Trust (2003). Updates 2005	Survey of the caseloads of community mental health teams in Manchester
Young people and adults of working age presenting with psychosis by Drake, r., Tarrier, N. & Lewis, S. (2005). University of Manchester	Prospective study of first episode psychosis in Manchester providing information about incidence, details on demographic and psychiatric profile and the extent to which people's needs were met.
Carers of people with mental illness in Manchester. MACC and Manchester Carer's Forum (2005)	Estimate of numbers of carers in Manchester from National and North West data and carers of people with a mental illness from local data. Overview of the priorities identified by local carers
Older people with mental health needs	The Report of the Acute Care Visioning Group (2004) refers to a current needs assessment process being undertaken by Professor Alastair Burns.
A study of the point prevalence of the in-patient population in Autumn 2005	Aims to establish the reasons for admission and the scope for alternative arrangements.
Black and minority ethnic elders commissioned from PRIAE in October 2005	Developing a strategy to improve the care and quality of life of Manchester's black and minority ethnic elders.
Needs assessment and Review of Older People's Mental Health Services in Manchester 2008	Currently being tendered for

Adapted from Health and Social Care Advisory Services (2006) Strategic Review of Mental Health Services in Manchester

Appendix D

Mental Health Pool Investment in Primary Care Services 2008/09

Provider	Service	Investment £
Manchester Community Health	Primary Care Mental Health Teams	
42nd Street	Suicide /Self Harm/Support for LGBs/ Young People under Stress	
The Roby	Counselling / Support	
Big Life Services	Therapeutic Services	
Self –Help Services	Primary Care Services	
African and Caribbean Mental Health Services	Primary Care Services	

Total

Appendix E

Scoping of Interpretation Services in Manchester

Purpose:

Following some concerns expressed at the Primary Care Oversight Group relating to the quality of current interpretation services in Manchester, a fact finding exercise has been undertaken to establish which interpretation services are currently used and what the experience of using these services has been for the Primary Care Mental Health Teams (PCMHTs).

Currents Service Providers:

- **M4 Translations** are an open access service based at the Town Hall; provided by the City Council Chief Executive's department. They provide interpretation and translation services in any setting during office hours, as well as evenings and weekends (through advanced bookings).

They employ 20 WTE and 300 session workers. Charges range from £22 to £75 per hour dependant on the language.

- **Manchester NHS Interpretation Service** is the PCT's In-house service provided from the Kath Locke Centre in Hulme. The service aims to supply interpreters for any required language and currently supports patients speaking around 80 different languages and dialects. The most commonly requested languages are Urdu, Arabic, Cantonese / Mandarin and Somali. The service is also experiencing significant increases in requests for Polish, Czech and Kurdish. This mirrors the profile of new incoming communities.

Access to the service is through faxed 24-hour notice and availability is comparable to M4 Translations service. In-house interpreters cost £37.00 for the first hour (and £8.75 for every 15 minutes thereafter). The main external supplier used charges £25.00 per hour (and £25.00 for each subsequent hour or part hour) plus £12.00 per hour travel time, in addition to expenses at 0.45 p per mile plus VAT. On this basis, the average agency booking works out at around £60.00.

PCT services also have access to a 24/7 telephone interpretation service which is charged at £2.00 per minute. This is also available to GPs.

Service Take Up:

The PCMHTs in North, South and Central areas currently only use the NHS Interpretation Service as there is no charge to them for this.

None of the PCMHTs have had experience of using M4 Translation services.

Concerns Identified:

The following feedback was received via email from the area PCMHTs.

▪ South Team

'Hi, I normally use;

- Manchester Mental Health Link Worker Scheme.
Co-ordinator: Mrs. Munawara Ali (0161 276 5259)

They are easy to access on the phone and offer a good professional service. They confirm the availability of the interpreter very quickly. The interpreters are familiar with mental health issues.

- Manchester NHS Link Worker Service based at Kath Locke Centre. Difficult to access. They require faxes of their referral form. Often faxes are not going through, frustrating. Takes a long time before they confirm the interpreter is available'
- 'Used the Deaf Services interpreters, and had found them to be very amenable and helpful'

▪ Central Team

'Use the PCT interpretation service. Quality varies since they use quite a lot of agency. There used to be a Mental Health Link worker Service based in MMHSCT which was great, but ceased business a few years ago now.'

- North Team

‘The only service we use is the Link Worker Service (Manchester NHS Interpretation Service). We have had lots of problems with them and I have reported these to the JCT in the past. Not turning up to arranged appointments is not uncommon, nor is sending an interpreter who speaks the wrong language. Getting confirmation of bookings is also a problem and I know that some of the clinicians have been unhappy with the approach of the interpreter’

Recommendation

The most sensible way forward would be for the PCMHT Leaders to raise any concerns with the Manager of the service provider as and when they arise or, if there are perceived to be any emerging patterns, concerns should be collated over a period of approximately two months and then presented to the Manager to see if they can be resolved.

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