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1. THE PURPOSE OF THIS FRAMEWORK

1.1 WHY WAS THE WORK COMMISSIONED?

The NHS Confederation and SHA Mental Health leads have commissioned Mazars LLP to produce a framework that provides practical help to CCG mental health commissioners. The aim is to help answer the question – “How does the CCG know it is commissioning effective community mental health services?”

Each CCG will need to assess its own requirements. The Framework is designed to be a flexible, easy to use resource to help them at a time when capacity is limited.

The Joint Commissioning Panel of the Royal Colleges of Psychiatrists and of GPs is leading a range of work to support mental health commissioning (see reference below). This Framework is intended to signpost key aspects of this and provides links to other relevant resources.

1.2 HOW WILL THE FRAMEWORK HELP?

This framework does two things:

1. Helps you identify if there are improvements needed in your local community mental health services.
2. Helps you make decisions about the changes needed to local services (if there are any).

1.3 HOW DOES IT WORK?

1. The framework identifies:
   • Key service “pivotal points”;
   • What you should expect from local services at each of these points; and
   • The questions you need to ask and the information you should be receiving to establish whether local people are receiving an effective and efficient service.

2. The framework provides resources to help conduct an informed dialogue around these issues by signposting and explaining:
   • The current and planned guidance;
   • User and carer views; and
   • The research and evidence base in this area.¹

3. The framework identifies the data / information you will need and helps interpret how this may be used.²

4. The framework is illustrated with a sample of case studies of emerging good practice that you may wish to consider for your area.

¹ This includes: the developing programme of work under the aegis of the Joint Commissioning Panel (JCP) (www.jcpmh.info), including the guides to Community Mental Health services and to Acute Care as it relates to crisis home treatment (due for publication in late 2012??) and summaries of evidence in “Cases for Change”.

1.4 WHICH SERVICES ARE COVERED BY THE FRAMEWORK?

The framework focuses on secondary care community mental health services for adults.

It does not suggest a single national approach to be followed locally. Whether local services are effective will, at least partly, be determined by:

- How well local objectives have been met; and
- By local service contexts e.g. the level of beds and the availability of social care.

In summary the framework is a working document, which signposts resources you can use and suggests questions to ask about services and service providers.

1.5 WHO PRODUCED THE FRAMEWORK?

The framework was produced a team provided by Mazars LLP an international financial and advisory organisation with a healthcare practice that specialises in mental health and was commissioned by the Mental Health Network of the NHS Confederation.

The framework was authored by Peter Finn (Mental Health Lead - Mazars) and included contributions from Mary-Ann Bruce (Head of Health – Mazars), Julie Stone and Dean Repper (Associate).
2. FRAMEWORK ON A PAGE

OVERIDING PRINCIPLES

Securing Common Values
(Section 4.2)

Reducing Inequality and Improving Primary Care
(Section 4.3-4.7)

FOUR AREAS OF FRAMEWORK

1. Assessment
   “Early with positive action”

2. Access to services
   “For it to be rapid it has to be easy”

3. Treatment
   “Never abandoned always enabled”

4. Management
   “Optimising the system”

WHAT ISSUES HAS THE CCG IDENTIFIED ABOUT CMHS SERVICES

Is there significant unmet need?
Could you maintain more people in primary care (PC)?
What can be done in PC to improve assessment?
Are assessments made in PC trusted?

Are your patients getting access to the right specialist MHS quickly enough?
Have you agreed the time it takes to access services?
Do you monitor performance against these standards?
Is it clear across the system how you access services?
What is the patient experience of access?
Are crisis teams seeing the right people and having an impact on care and levels of admissions?

Are your patients getting to see the right specialist service and then receiving effective interventions?
Do services have the right kind and numbers of staff?
Are your patients given a choice in how they get care e.g. supported at home?
Do your patients have better mental health after contact with specialist MHS?

Do the arrangements for discharge from MH services work well?
Are people staying on the Community caseload too long?
Do you have access to good discharge information?
Do users know how to re access services?
Are people with mental health problems in stable accommodation?
Do local services work effectively with each other?

FRAMEWORK REFERENCE

Section 4.3
Section 4.4
Section 4.5
Section 4.6

ARE WE WORKING IN PARTNERSHIP TO BE SUSTAINABLE? (SECTION 4.7)
3. WHY IS THIS IMPORTANT?

See [appendix one](#) for a brief summary of the background and context to these services.

Effective commissioning is important for a number of reasons:

- It is a core part of your responsibility. The mental health strategy “No Health without Mental Health” focuses on outcomes. This means that local service investment / configuration is a matter for local determination by you, service users and providers.
- Effective community mental health services will help you achieve a range of objectives including reducing inequalities.
- Much money is spent on it – though not necessarily enough (see below)
- Mental health problems are common and rising.
- Even though prevalence is high, the level of need identified and then met through a statutory service is low.
- Spend on mental health services can be highly effective. Improving mental health helps improve physical health. A lot of people attending your surgeries will have medically unexplained symptoms or physical problems caused or exacerbated by mental health problems.
- Service users have told us what they want from community mental health services.
- The CCG has a number of statutory obligations ([see appendix two](#)).
4. KEY QUESTIONS AND HOW THEY MIGHT BE ANSWERED

4.1 INTRODUCTION

There are often critical parts of a local mental health system, which if commissioners (and other stakeholders) get right, will enable the whole patient pathway to work effectively. These offer a way to focus commissioner time and to maximise the impact of commissioning decisions and interventions. In the sections below we identify those parts of any service that have a potential for profound impact on population health – good or poor and which, of course, will determine both the effectiveness and efficiency of a mental health service.

4.2 A “VALUES BASED” SERVICE

Why is this important for the CCG?

CCGs are tasked with developing health care systems that are: local, collaborative, user-centred, based on effective partnership working and cost effective. Identifying and agreeing common values with all partners involved will lead to greater success with this endeavour.

In health care it is now recognised that achieving good general health is a collaborative process between individuals, communities and health providers. Health and Wellbeing Boards will set a strategic context to healthcare developments. Each CCG will consult widely with the communities they serve to determine services that it will commission. This consultation process is sure to identify those values that it would expect services to adhere to. Those values should then be a reference point for addressing service issues as they occur.

The JCP has identified the underlying principles for a specialist community mental health services in its guide. These will be important as service models will vary according to local circumstances and population but principles should be more enduring.

The principles proposed by the JCP are that community mental health services should be:

- User-centred
- Equitable
- Non-discriminatory
- Capable
- Multidisciplinary
- Available and making use of evidence-based interventions
- Outcome focused
- Recovery-focused
- Based on user involvement and that of their support network, including carers.
How does the CCG know it is commissioning effective community mental health services?

You should expect:

- A strategy for mental health that starts from a values perspective and organising principles of service provision, which in time should be matched by key indicators of performance.
- Locally determined values, or those of the JCP if adopted, should be demonstrated across all services.
- Users, referrers and partners to mental health provider organisations should be actively encouraged to be involved in all planning of services.

Modernising Adult Mental Health Services In Bristol Consultation

The PCT has decided to re-commission all local mental health services and as part of this is developing a new model of care and pathways. This is based on a set of values and principles that include:

- Working with patients to promote resilience and wellbeing and service design & delivery
- Being inclusive
- Be locally accountable and Bristol focussed
- Meet the diverse needs of Bristol’s population
- Deliver high quality services regardless of age
- Consider the wider context of the patient
- Recognise and deal with safeguarding issues
- Focus on service user outcomes rather than activity (i.e. results rather than numbers).

Bristol’s Emerging Model of Care

Multiple access points which can provide information, signposting and/or intervention.

A decreased and refocused in-patient/secondary care element enabling a greatly expanded community/primary care component.

Specialist care to advise/ support primary care

This model should link with and influence all the city agencies and strategies which help to improve mental wellbeing.
Key Questions

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<thead>
<tr>
<th>Questions</th>
<th>Possible interpretation</th>
<th>Potential action</th>
<th>Relevant Data and availability</th>
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<tbody>
<tr>
<td>Has the CCG agreed with stakeholders and providers local values and principles of service provision?</td>
<td>If absent it may demonstrate a lack of system maturity and grasp of importance of culture on healthcare outcomes and user views.</td>
<td>Consider facilitation from outside the system of key partners.</td>
<td>JCP principles (above) as basis for discussion</td>
</tr>
<tr>
<td>Do any of these values and principles lend themselves to routine measurement and/or audit?</td>
<td>If so have the CCG agreed acceptable performance levels and/or objectives? If evaluation through measurement and/or audit is absent then users may view values not taken seriously.</td>
<td>CQC reviews and surveys will often reflect key values e.g. user involvement and can be used to benchmark services and set performance levels.</td>
<td>CQC reviews and surveys Local providers may have local leadership / cultural surveys</td>
</tr>
</tbody>
</table>

Given the huge importance of shared values to achieving strategic change you may wish to consider further action having considered the following:

- How informed do you feel about service adherence to agreed principles?
- Was this information easy to obtain and do you believe it to be reliable?
- Are you confident about the service progress towards objectives based on this information?
- Are you encouraged about this progress and optimistic for future service delivery in line with objectives?

Useful Resources

<table>
<thead>
<tr>
<th>Document / organisation and Links</th>
<th>Why it is useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Commissioning Panel Guidance for Commissioners of Primary Mental Health Care Services</td>
<td>Identifies key underlying principles of services based on wide stakeholder discussion. Page 8.</td>
</tr>
<tr>
<td>Service User Research Network</td>
<td>Have conducted a lot of research from the user perspective and shown the importance of the underlining value base.</td>
</tr>
<tr>
<td>Staff and Community Mental Health surveys</td>
<td>Will provide evidence of how well NHS providers perform against key agreed values or principles. Each trust was provided with a benchmark report on its scores in the survey. This enables them to benchmark their performance against all other trusts and identifies areas for improvement. For example MH Staff survey will provide evidence on training (Qs 5. and 6.).</td>
</tr>
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</table>
4.3 RECOGNISING MENTAL HEALTH NEEDS / ASSESSMENT ‘EARLY AND WITH POSITIVE ACTION’

Why is this important for the CCG?

Properly identifying mental health need at a population level and ensuring good assessment in primary care is key to ensuring good access to appropriate community mental health services (further information in JCP Public Mental Health Guide). It will help the CCG assess if it is buying the right level and balance of services and help ensure early access to appropriate services for individuals who present with a mental health problem.

GPs have a vital role in the early stages of an individual mental health assessment in identifying need and matching this to available services, but need support to do this effectively.

We know from the Layard report that much mental health need remains untreated. Making early identification with positive action a critical objective will have profound impact on a local community’s mental health and in some cases physical health.

How does the CCG know it is commissioning effective community mental health services?

The CCG should expect:

- Visible health promotion initiatives (in conjunction with the HWB) with a positive image of mental health. This is particularly important for black and minority ethnic groups/conditions/ages that have low rates of access
- Primary care and other frontline services (police, prison staff, housing, social care, benefits, voluntary sector) should have access to up to date training in MH awareness and appropriate first line responses e.g. mental health first aid
- Mental health specialists (MHs) should be easily accessible to the primary care team;
- Access to named mental health specialists (MHs) to provide advice and support within working hours for routine primary care consultations
- Outside routine hours there should be a dedicated emergency/crisis response for the whole community and for emergency services, including A&E departments, ambulance service and police
- Training and education in the early identification of mental health needs and support with assessment tools should be available e.g. use of depression screening tools for general population and pregnant women
- GPs and other staff should feel their assessments are valued, respected and decision making trusted and positive action taken when requested.

1 No Health without Mental Health p37
### Key questions: how effective is the CCG at identifying and assessing mental health need?

<table>
<thead>
<tr>
<th>Questions</th>
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| Do you know how many people in your area have mental health problems?     | A low rate of MH problems could result from:  
   - Communities being fearful to come forward, lacking information about what to do, or poor self-identification of need.  
   - Primary care practitioners have inadequate training to identify need or access to support with patient consultations.  
   - Possible access issues or poor service availability  
   Low rates of identification could result in more crisis presentations: as the need goes untreated, it escalates.  
   High rates of identification could be due to:  
   - recent local population or social/economic changes affecting MH rate  
   - Or inadequate training and misinterpretation of some presentations as a MH need as opposed to a transient emotional cycle of change. | What MH promotion strategies are in place?  
   Review training needs in PC.  
   Are there high levels of contact between PC and MHs?  
   Review public health data and/or conduct local consultations with communities and other agencies. | **MHMDS** – record for each patient receiving care within the Mental Health Service  
**QOF** – MH Prevalence  
**JSNA** – MH prevalence and population/ socio-economic changes. |
| What is the rate at which PC identifies MH problems in the local community? | Low rates may indicate:  
   - High levels of tolerance, capacity and capability within PC, with good shared protocols in place with MHs that support management in PC.  
   - Needs to be seen in context of crisis presentations. If crisis episodes are high this might be an indication that people are held in PC without the effective interventions.  
   - Long waiting times can also lead to holding off on referrals, creating a ‘no point in referring’ attitude.  
   - Knowing access to routine hours support is available can increase PC management of appropriate levels of need.  
   - Are local communities and PC confident about local services and what they offer, if low they may be reluctant to refer or patients to accept a referral.  
   High referrals may indicate  
   - low tolerance, capacity and capability in primary care  
   - low confidence in primary care services  
   - low thresholds for referrals to CMHS | Review training and support systems, including screening tools.  
   Are there shared care protocols between PC and MHs?  
   Review waiting times.  
   Is good information available to PC and patients on treatments available and its benefits?  
   Is there good feedback from service users raising communities and PC confidence to use local services?  
   Is the right balance and range of services available | **MHMDS** – referral data and Waiting time information  
What is the case mix of CMHS caseload? this will give a better sense of who is seen in CMHS and who maintained in PC |
### Questions

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<tr>
<td>When you refer someone to specialist mental health services is it clear to you and the service user how best to access the service? Are there multiple points of entry to care which makes the pathway difficult to understand?</td>
<td>How many patients are sent by PC to an appropriate pathway/assessment team if no single point of access exists (SPA)? SPA not always appropriate and should be subject to local negotiation. Service users can be referred on following assessment. The important factors are easily understood referral mechanisms and that when possible assessments are not duplicated. Where there is no SPA and PC need to send someone direct to a specific pathway/team, a high level of redirection of those patients (leading to potential for duplication and drop out rates) may indicate • poor definition of need in PC • and/or lack of information about what teams/pathways offer.</td>
<td>Review support systems for PC and service information on what works for what needs.</td>
<td>GP Practice Records – patient referral</td>
</tr>
<tr>
<td>What is the overall access rate for the local population to specialist mental health services?</td>
<td>Overall rate can be used as a headline indictor</td>
<td></td>
<td>MHMDS – number of MH service users</td>
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### Useful Resources

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| PHQ-9/GAD-7 assessment tools     | Provides structure for assessment  
For both PHQ and GAD <5 is normal. >10 clinical threshold, and more than that indicates more severity                                                                                                                  |
| How Mental Health Loses out in the NHS, June 2012 | Understand the priority needed in commissioning mental health services                                                                                                                                                   |
| DH Resource pages on Mental Health PbR Care Pathways and Packages Project | Considerable national and local effort has been made to develop PbR in mental health. While a national tariff is some way away, contracting will focus increasingly on the currencies developed around the 21 “Clusters” and local pricing.  
While much of the focus has been on technical issues around the introduction of PbR it also provides the potential for moving away from block contracts, having more discussion around outcomes and service transformation. |
4.4 ACCESS TO SPECIALIST HELP (INCLUDING FOR CRISIS) ‘FOR IT TO BE RAPID IT HAS TO BE EASY’

Why is this important for the CCG?

The Joint Panel “Guidance for Commissioners of Community Specialist Mental Health services” highlights the need for good timely access to the right service and the indicators of services were this isn’t working well. For example, delays in access, boundaries that enforce exclusion / inclusion criteria etc.

If identification of need has to be early then access to the care and treatments will need to be easy and in some cases rapid. Certainly when people are in crisis then access to help should be immediate as a risk to self and in a few cases, to others can occur. Timeliness of access to treatment will of course be proportional to the severity of need. For some needs delay can have profound impacts, especially psychosis. The JCP guide on Acute Care – inpatient and Crisis Home Treatment suggests that an assessment in “around 4 hours may be appropriate”.

There is significant evidence that early intervention in mental health not only improves clinical outcomes but is also cost effective (see ‘Cases for Change’)

How does the CCG know it is commissioning effective community mental health services?

The CCG should expect:

- To know if there is a single point of access or that there are alternative options to refer to dependent on the identified and severity of needs. Whatever the local practice, it should be agreed by the CCG and provider

- The pathway should aim to avoid duplication of assessment if possible. Some Trusts have begun to accept the assessments by GPs as a sufficient basis for directing patients on to specific parts for the pathway

- For a standard non-urgent need an identified service/pathway to refer to and in some cases allocated consultation appointments to choose from (or for the patient to opt into)

- For urgent cases and emergencies in primary care, current and previous patients should know that there is a dedicated rapid response service or specialist team that will operate 24/7 (those at risk who are in the service or who have been previously seen should know exactly when and how to access crisis/rapid response service)

- That all partner agencies including frontline social services, housing and police are also aware of how to contact the service

- If a patient on the GP list contacts or is admitted to the service out of hours, the named GP should be informed the next working day

- While a SPA is becoming the norm it is also desirable there should be multiple referral points e.g. not just the GP, from within the community and from other frontline services, including self-referral (where agreed between commissioner and provider)
Wolverhampton Mental Health services

In secondary care needs were not met in the way we wanted and people had limited access to psychological help. Caseloads were high and stopped a proactive approach. Referrers and service users were confused by the multiple points of access and number of different teams. We set up a primary care facing mental health service (called Healthy Minds and Wellbeing Service) and consolidated the CMHTs and other teams into a complex care service. To manage referrals and urgent care we set up a SPA team called the 'Referral Assessment Service'.

There are distinctive advantages to the new arrangements. Complex care adopted lower caseloads so they can provide an intensive support to those with multiple needs and at higher risk of falling out of services. While the primary care team can offer shorter duration of care based on best available psychological interventions and support stable clients back to primary care. It has moved away from an outpatient model. Much closer relationships have been fostered with GP’s, the voluntary service and social care.

The changes have enabled the Trust to start a discharge process for service users who can be managed in primary care, utilising shared care protocols with GP’s.

Rotherham, Doncaster and South Humberside MH Trust
‘providing for unique needs with tailored pathways’

The needs associated with MH problems are not all the same. A ‘one size fits all’ approach would not fit yet CMHTs are often trying to meet an increasingly wide spectrum of needs. Some of this has arisen as referrers have become increasingly aware of different types of presentations but also because we know a lot more about what works for whom and their needs.

The Trust had also received feedback from service users that there were issues around access, they faced duplicate assessments and it was difficult to move around services.

The Trust set up a Single point of Access (SPA) that would be managed by a dedicated ‘Access Team’, this would include crisis referrals. This team would identify the most appropriate care pathway and the service user would be taken on by a team that could provide the best suited intervention for that set of needs. Service users would receive dedicated support based on their needs and most up to date interventions for their level of complexity. Primary care would be supported by a dedicated Access Team and would know that their patients were receiving appropriate intervention for level of need.
Leeds & Yorkshire NHS Trust
“right service, right time and right place”

The Trust faced rising frustrations from referrers about access to Mental Health Specialists (MHS). With an already successful Single Point of Access (SPA) operating for Learning Disabilities, the Trust started a change process that would give referrers an SPA for mental health problems, this included Urgent Referrals, those who needed to be seen the same day. This service covered S136 (emergency mental health act applications by the police) and emergency department presentations.

The aim is to support service users to stay within a community setting and only using an acute/admission to bed where appropriate. It will also aid clinician to clinician dialogue so primary care can make decisions based on needs and knowledge of interventions available.

A critical attribute of the team is their multi-disciplinary make up, with Psychiatrists, Mental Health nurses, Social workers, and AMHP and support workers. This allows the team to make a comprehensive and holistic assessment and importantly know which pathway to direct service users to following stabilisation of the crisis.
### Key Questions: is the CCG ensuring timely appropriate access to specialist mental health services including for crisis services?

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<tr>
<td>Are your patients getting access to the right specialist MHS quickly enough?</td>
<td>Undue delays could increase DNA rates and may be due to capacity factors, which could be resource based or related to poor efficiency of processes</td>
<td>Agree a capacity model that optimises lean processes (simulation modelling may help). Consider opt in appointment approaches</td>
<td>MHMDS – Referral Data</td>
</tr>
<tr>
<td>What is the time from referral from PC to specialist assessment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is time from this assessment to treatment start?</td>
<td>Similar to above</td>
<td></td>
<td>Provider data</td>
</tr>
<tr>
<td>What is the Rate of emergency use of MHA e.g. S136 police powers?</td>
<td>A high rate may be indicative of poor engagement of users, lack of access out of hours or knowledge on how to use services</td>
<td>See section on “values based service”</td>
<td>MHMDS - Data on use of MHS including S136. CQC patient survey</td>
</tr>
<tr>
<td>Does the local provider have a high DNA rate?</td>
<td>Poor initial engagement, inassertive follow-up (e.g. lack of attempts at telephone contacts when DNAs occur), and inefficient administrative processes can lead to high DNA rates and also inadequate explanation about referral to potential service user by the referring agent</td>
<td>Ensure audit of reasons for high DNA rates occurs and remedies sought</td>
<td>DoH Hospital Activity Data – Did not attend data</td>
</tr>
<tr>
<td>What is the rate at which patients move pathway or PbR cluster in the first month of service contact?</td>
<td>High rate maybe indicative of inferior initial assessments or poorly articulated objectives of pathways. If this prevails is it true for all clusters? May indicate effective interventions for crisis.</td>
<td>Front loading expertise at the assessment stage will help and using up to date research and user views when constructing pathways</td>
<td>MHMDS – Payment by Results Care Cluster data</td>
</tr>
<tr>
<td>What is the experience of your patients of accessing specialist mental health services?</td>
<td>Does the service user have a contact number for someone from their local mental health services to phone out of office hours? For those that had used this number in the last 12 months, not having a problem getting through to someone? For those that had used this number in the last 12 months, getting the help they needed, the last time that they called this number?</td>
<td></td>
<td>CQC mental health survey - Overall Crisis care Q36. Out of hours contact Q37. Getting through to someone Q39. Getting help</td>
</tr>
<tr>
<td>Are Crisis teams seeing the right people and having an impact on care and the level of admissions?</td>
<td>Trusts will monitor the “gatekeeping role” of CRHTs. However CCGs need to consider not just that people in crisis have been seen by a team but that the assessment has been effective. Has a realistic alternative to admission been considered?</td>
<td>Monitor the care cluster of patients on a team’s caseload. Are the teams focusing on the agreed PbR clusters?</td>
<td>MH Community Teams Activity Return – Admissions gate kept by the CRHT. Mental Health Trusts PBR Care Cluster data</td>
</tr>
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</table>
### Useful Resources

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<tbody>
<tr>
<td>1. <em>Cases for Change</em></td>
<td>These documents pull together available service research and NICE guidelines. They are organised around severity of need (mild, moderate, severe) but also relate to PbR clusters and diagnosis. Would be helpful aid to designing services.</td>
</tr>
<tr>
<td>2. Joint Commissioning Panel for MH</td>
<td>The Joint Commissioning Panel for Mental Health is collaboration between leading organisations with an interest in mental health and learning disabilities. It works with the Royal College of General Practitioners and their Centre for Commissioning, and also builds upon the National Mental Health Development Unit’s previous work on commissioning and mental health.</td>
</tr>
</tbody>
</table>
4.5 CARE INTERVENTION AND ON-GOING MANAGEMENT ‘NEVER ABANDONED AND ALWAYS ENABLED’

Why is this important to the CCG?

It goes without saying that once someone is in the care system they and their family/carers should receive optimal service and evidence based interventions. This ensures a timely return to daily functioning and independence from services. We now know that there is a range of effective interventions for most MH problems and research is growing all the time. Knowing what is effective and using outcome data as it becomes available will enable the CCG to ensure the best use of available resources.

How does the CCG know it is commissioning effective community mental health services?

The JCP is clear that:

“There is no single “optimum” model of specialist mental health service. The key components ... comprise a core CMHT or recovery team supported by a number of more specialist service components of which the best evidence appears to support EIP and CRHT teams. In the event that it is decided not to commission stand-alone AO team, the CMHT/recovery team must be sufficiently resourced to provide an AO function. Teams should be multidisciplinary and recovery-focused. Local models should be developed to take account of local demographics and need. Whatever model is agreed, it must be driven by clear care pathways that are understood with the service and partner services, especially primary care”.

The CCG should expect:

- That CMHS will offer a range of services which are NICE compliant (see ‘Cases for Change’)
- That those services are part of a coherent system of care pathways, grouping needs according to agreed principles e.g. diagnosis, severity, PBR clusters, speciality, volume etc.
- The JCP suggests a Stepped Model of Care in which CMHS provide high intensity psychological therapies and/or medication for people with more complex needs along with specialist mental health care, including extended and intensive therapies.
- That the workforce will be multi-professional and have the skill mix, diversity and expertise to deliver the NICE guidelines. The Joint Commissioning Panel has summarised what a good specialist community mental health service will look like.
- That the GP and the patient will have a clear picture of the assessment outcome, care plan and likely length of treatment, with regular review letters to the GP if in the service more than 3 months.
- Where a patient is likely to receive multiple points of support that there is one overall care co-ordinator who will be a named contact for patient and the PC team
- That engagement for patients who are either chaotic or find taking up support difficult but not to do so could be detrimental to their health, will be positively and assertively followed up, with discharge from service agreed with GP
- That CMHS will offer a range of support across the needs spectrum from appointment based meetings, home visits (from weekly to daily), groups, short term residential accommodation that is non-acute in order to maximise care in the least restrictive environment.
Head4Health was designed to comprehensively review and improve clinical pathways for patients referred to Community Mental Health Teams (CMHTs).

We wanted to develop a model of service delivery that would offer:

- Rapid access to expert opinion, assessment and diagnosis
- Elimination of the need for repeated assessments, by front-loading expertise at the point of referral, thus increasing efficiency and improving patient experience
- Cost-effective, evidence-based treatments focussed on recovery
- Improvements in patient choice, particularly as regards access to psychological therapies.
- Safe and effective step-down care for patients no longer requiring secondary services.

Summary of the model:

- Immediate screening for urgency, and urgent assessments undertaken same day by a dedicated duty clinician
- Daily meetings of senior clinical staff to triage routine referrals, delivering multi-professional preliminary formulation within 24 hours.
- Immediate onward referral to more appropriate services, for those cases not requiring secondary mental health care
- Initial assessments undertaken within 28 days by the most appropriate senior clinician(s) (e.g. Consultant Psychiatrist, Psychologist, Psychotherapist, Senior Nurse)
- Development and delivery of a structured treatment plan, using specifically-designed pathways based on diagnosis, care cluster and formulation, in accordance with NICE guidance with an emphasis on patient choice.
- Focus on adding value, by ensuring that all staff have clear roles which are evidence-based.
- Clear exit pathways, including a novel recovery-based step-down service for those with on-going, but less complex needs, and a rapid re-access service, allowing patients to have direct access for 12 months after discharge.
- Work with partners to support them managing those with on-going difficulties, including close liaison with GPs
Recovery Colleges and peer to peer support
“becoming the people they want to be”

We know the importance of self management/care and prevention strategies for physical health long term conditions (LTC). A tradition has developed with LTC in physical health care of patient expertise and often patient to patient education. While MHS have considerable experience of managing LTC for mental health problems we have lacked a coherent model for moving from professional management to a patient based self management process.

If we successfully move to strengthening peoples own self management and increase peer to peer support (the accepted title for patient to patient support in MH), this will have benefits for both MHS and Primary Care (*Implementing Recovery: A new framework for organisational change. Position Paper, 2009*).

Wide spread provision of Recovery colleges (sometimes called Recovery education Centre) would have a profound and innovative impact on MH. A number of demonstration sites have been set up ([Click here for sites](#)) and are rolling out the benefits to others.

“We learn from each other and we inspire each other to help our students (service users) on their road to recovery. You see the positive change in students – becoming the people they want to be.”

A move from a therapeutic to education approach has many advantages and shifts the relationship between professionals and service users, in a way that promotes self management and building people’s strengths.

An educational approach focuses on learning and goals and enabling people to understand their own challenges and how they can best manage these.
Worcestershire Early Intervention Service for Psychosis
‘promoting a family orientated service’

Referrals are accepted for young people aged between 14-35 years (14-16 year olds are managed in partnership with our local Child and Adolescent Mental Health Service (CAMHS)). Any agency with concerns that a young person may be developing a first episode of psychosis can request a specialist assessment from the service. Self-referrals from young people and their families are also accepted. The young person is contacted within a week from referral and seen within 2 weeks at a venue of their choice, typically the family home, school or college. The majority are seen weekly and treated at home throughout their psychosis.

If the person is acutely unwell, the team has the capacity to visit daily and, in conjunction with Crisis and Home Treatment team colleagues, support can be offered to the individual and family in evenings and over weekends. It may not always be possible to manage the psychosis at home and a decision to bring the person into hospital is made in collaboration with the family. The service aims to use the least restrictive actions and the majority of individuals are admitted to hospital voluntarily with limited use of compulsory detention under the Mental Health Act (1983). The service aims to minimize the length of stay in inpatient care and get the person back out in the community as soon as possible with an appropriate level of support from the team agreed in collaboration with the young person and their family.

The individual and their family are offered timely evidence based best practice interventions typically including low dose atypical medication, Cognitive Behavioural Therapy (CBT), Individualized Placement Support (IPS), family intervention and relapse prevention strategies as part of the overall care package. Individuals may also be invited to participate in group based activities including regular weekly social and leisure activities such as football, walking, badminton (led by team members using ordinary community leisure and sports facilities), a social confidence group for young people with social anxiety difficulties, an educational and vocational support group for young people planning to return to college/work or a voices group for young people who experience auditory hallucinations.
## Key questions: how do we assess that local community mental health services are effective?

<table>
<thead>
<tr>
<th>Questions</th>
<th>Possible interpretation</th>
<th>Potential Action</th>
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<tbody>
<tr>
<td>Are your patients getting to see the right specialist service and then receiving effective interventions? Are services seeing the right people?</td>
<td>Early PbR data suggested differing case mix on the caseload across MHTs. Initially this may reflect differing use by clinical staff of the clustering tool but can also illustrate differences in the caseloads of specialist services e.g. if there are a relatively high proportion of the caseload in clusters 1 to 3 with short-term ‘Common Mental Disorders’, this may indicate limited availability of primary mental health care including IAPT services or shared care between services. This could be appropriate if by caring for this group in secondary care, the service maintains individuals and helps prevent deterioration in mental health.</td>
<td>MHMDS – Payment by Results Care Cluster data</td>
</tr>
<tr>
<td>Are the interventions provided to service users effective?</td>
<td>Trusts should follow NICE Guidelines and regularly conduct audits to check compliance especially with interventions recognised to be valued by service users but often unavailable, e.g. ‘talking treatments’ What are the audit results? Are there areas where compliance is low and what are the reasons?</td>
<td>Mental Health Trusts</td>
</tr>
<tr>
<td>Do services have the right kind of staff and enough of them to provide NICE complaint services?</td>
<td>The JCP recommends a professional balance. What is the professional mix and balance of the CMHS?</td>
<td>NHS Iview – Staff-In-Post (Headcount, FTE, Assignments)</td>
</tr>
<tr>
<td>Are staff trained in accredited NICE approved interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are staff generally well trained, led and motivated</td>
<td></td>
<td>NHS staff survey</td>
</tr>
<tr>
<td>Is communication between CMHS and PC effective?</td>
<td>What is the % of patients who have care plans and GPs who have assessment letters and review letters in a timely manner Is this monitored locally?</td>
<td></td>
</tr>
<tr>
<td>Are your patients given a choice in how they receive care? Are you concerned that people who have a mental health crisis are not being appropriately supported to stay at home?</td>
<td>Are you concerned that too many people are being admitted to hospital that might have been supported at home? Can community based crisis teams demonstrate an impact on patient pathways that goes beyond “gatekeeping”?</td>
<td>DoH KH03 return – Bed Availability and Occupancy – Overnight</td>
</tr>
<tr>
<td>Is the balance of commissioner spending across community and inpatient services investment right?</td>
<td>% of spend on beds to community based services How do the respective levels of investment in community and inpatient services compare? Do you have a high level of investment in both? Is there scope to reinvest into community services?</td>
<td>Reference costs</td>
</tr>
</tbody>
</table>

*Notes:*
- MHMDS = Mental Health Minimum Data Set
- NHS Iview = National Health Service Information View
- NHS staff survey = NHS staff survey
- DoH KH03 return = Department of Health KH03 return
- Bed Availability and Occupancy – Overnight = Bed Availability and Occupancy – Overnight
- Reference costs = Reference costs
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<tr>
<th>Questions</th>
<th>Possible interpretation</th>
<th>Potential Action</th>
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</thead>
<tbody>
<tr>
<td>What is the % patients who access crisis services from within other care pathways?</td>
<td>For example A+E. Is this higher than elsewhere / expected. Does this suggest an effective pathway? Are service users going via A+E when they should be accessing CMHS? Are there times of the day / week when this happens?</td>
<td>IC’s practice level A&amp;E attendance data for MH HES</td>
</tr>
<tr>
<td>Do your patients have better mental health after contact with specialist MHS?</td>
<td>The availability of routine outcome data that covers –</td>
<td>Trust HONOS data</td>
</tr>
<tr>
<td>What evidence is there of improvement in outcomes?</td>
<td>• Social functioning, including work and/or education</td>
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<tr>
<td></td>
<td>• Symptom relief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Accommodation status</td>
<td></td>
</tr>
<tr>
<td>How does the Trust compare on nationally available data on outcomes?</td>
<td>National data on outcomes has been limited but has been the focus of national work, such as that of the Outcomes Sub group of the MH PbR Workstream. For each cluster a small number of quality indicators, between 1 and 3, should be agreed in 2013/14. • The proportion of users on CPA with a crisis plan in place • The accommodation status of all users (as measured by an indicator of settled status and an indicator of accommodation problems) • The completeness of ethnicity recording • The proportion of users in each cluster who are on CPA • The proportion of users on CPA who have had a review in the last twelve months • The proportion of users who have a valid ICD10 recorded.</td>
<td>MH Dashboard</td>
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<tr>
<td></td>
<td></td>
<td>PbR Outcomes Group 7 key indicators from MHMDS.</td>
</tr>
<tr>
<td>What local standards have you agreed and are they being met?</td>
<td>What information do you have to monitor compliance or progress?</td>
<td>Local data</td>
</tr>
</tbody>
</table>
## Useful Resources

<table>
<thead>
<tr>
<th>Document / organisation and Links</th>
<th>Why it is useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NICE guidelines and summaries of best practice are summarised in the Cases for Change documents</td>
<td>This provides the best available evidence of effective mental health practice. Mental Health providers should conduct regular audits of compliance enabling the CCG to adopt an evidence based approach.</td>
</tr>
<tr>
<td>The Joint Commissioning Panel Guidance for commissioners of Community mental health services</td>
<td>Key stakeholders have summarised what a good specialist community mental health service will look like.</td>
</tr>
<tr>
<td>The Joint Commissioning Panel Guidance for commissioners of Primary Mental Health Care Services</td>
<td>Describes how community mental health services can best relate to primary care e.g. see page 9 for key components of service.</td>
</tr>
<tr>
<td>The Joint Commissioning Panel Guidance for Commissioners of Acute Care – inpatient and Crisis Home Treatment Add hyperlink to pages 12 to 14 in draft</td>
<td>Describes what good community acute care looks like</td>
</tr>
<tr>
<td>Review of Effectiveness of Multi-Professional Team Working (MPTW) in Mental Health Care</td>
<td>Describes effective MPT working</td>
</tr>
</tbody>
</table>
4.6 DISCHARGE AND HANDOVER TO PRIMARY CARE ‘OPTIMISING THE SERVICE SYSTEM’

**Why is this important to the CCG?**

In most cases treatment of MH need will come to an end. For some cases this will be within a relatively short period, although there will be some patients who may remain in treatment for several years. In any case, it is important that there are clear local arrangements, based on well documented plans, which enable service users to re-access care easily.

Systematic and orderly discharge back to primary care will mean that services can operate at optimal capacity. It will also promote an overall goal for patients that a return to independence and daily activities is possible.

**How does the CCG know it is commissioning effective community mental health services?**

The CCG should expect that:

- On entry to care an indication of length of the care episode is provided with regular review statements, e.g. re-clustering data, when the care episode is over 3 months (e.g. under 6 months, 1-3 years, over 3 years, or liable to relapse)

- For those with a longer care episode involvement in discharge planning, especially where high cost placement may be contemplated, and general agreement for approaches for those with high risk or and poor service engagement

- Shared care protocols are available and implemented

- Outpatient clinics are reserved for those in active treatment, at risk and for those needing urgent attention from PC

- For those with episodic problems discharge should be managed closely with the GP and accessing services again should be easy and quick. Patients and GPs should be aware of early warning signs for relapse, where these can be identified.

- People with chaotic life styles or those at high risk should not be discharged without agreement with the primary care team.

- In some cases a shared care protocol might be helpful to the GP, where the GP takes on active management but has immediate access to consultation or a treatment team.
### Key questions: how do we assess that discharge and handover arrangements are effective?

<table>
<thead>
<tr>
<th>Questions</th>
<th>Possible interpretation</th>
<th>Potential Action</th>
<th>Relevant Data and availability</th>
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</thead>
<tbody>
<tr>
<td>Do the arrangements for discharge from MH services work well?</td>
<td>A comparatively low rate might indicate a reluctance to discharge back to PC. It may though be an indicator of people with significant MH problems being maintained in the community. One consequence could be access problems for new referrals.</td>
<td>Review shared care protocols. Review capacity/volume across pathways. Comparisons of length of time on the caseload by cluster may help indicate what should be the focus of any review.</td>
<td><strong>MHMDS</strong> – Referral Data</td>
</tr>
<tr>
<td>What is the rate of discharge from community caseloads?</td>
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<tr>
<td>Do GP’s have access to discharge review meetings and good discharge information?</td>
<td>Lack of involvement may lead to misunderstandings on follow up support by the GP and how to manage relapses or re-engage the team.</td>
<td>Where do discharge reviews take place? What ways can care coordinators liaise with the GP?</td>
<td><strong>NA</strong></td>
</tr>
<tr>
<td>Do users have a clear understanding of how to re-access services?</td>
<td>Inadequate plans on discharge could lead to unnecessary use of crisis services rather then accessing support through previous treatment team.</td>
<td>Ensure staff trained in relapse prevention and ensure information is available in different formats and early warning signs recorded</td>
<td><strong>Case note audits</strong></td>
</tr>
</tbody>
</table>


4.7 CRITICAL INTERFACES AND PARTNERSHIPS ‘NO FIXED WALLS, BOUNDARIES WITH A PURPOSE AND PARTNERS WITH COLLABORATIVE GOALS’

Why is this important to the CCG?

With any delivery of a service there will be interfaces, boundaries that mark where one service begins and another ends. Effective working within and across these boundaries will maximise system capacity e.g. the use of inpatient beds.

Boundaries support a defined service function and the skills and experience required to deliver it. When these services work well they optimise the flow and volume of need that can be met in a complete service delivery system. Boundaries act as a hand off point, a transition phase between practitioners in the care of patients, they should not behave as fixed walls that both patients and practitioners have to scale or knock down.

Equally important will be effective partnership working by organisations that provide CMHS. Partnerships will define how capable a whole system is, does it have the maturity to jointly problem solve issues affecting the whole system.

A CMHS will have to work collaboratively with partners and in some cases offer consultations or access to its services where the need cannot be managed in the partner organisation. When the capacity and capability of the system is tested and found wanting patients will end up in the wrong services, with appropriate care delayed or a part of the system too full to take on care. In some cases some patients will be at risk and some care providers overstretched and also put at risk.

How does the CCG know it is commissioning effective community mental health services?

The CCG should expect:

- The local MH strategy should clearly define all the relevant partners and the forums within which it expects local CMHS to be active
- A local service should be in place to meet all needs providing care close to home/community and in the least restrictive environment with the exception of low volume/specialist needs
- Volume of need should have been predicted and service/pathways have indicators of capacity it can meet with desirable outcomes
- Defined care pathways and services with clear entry and exit criteria and the sum of these should cover all the need that will arise in a local population
- Step up and step down criteria should be clear for both patients and the GP when stepped care models are used
- Senior leaders from CMHS providers should be visible in resolving interface conflicts and disputes and regularly report resolutions through the relevant CCG provider management forum
- CMHS should have up to date protocols with all relevant partners and for some services named managers and lead clinicians those partners can contact to resolve MH issues facing partners and regular planning meetings to proactively manage partnership goals
- It should be clear where disputes are resolved between partner organisations and when commissioners will step in
- All operating personnel and clinicians in a CMHS should be up to date with all safeguarding procedures and should be seen to participate in safeguarding forums
- Investigations into untoward incidents and complaints should consider partnership factors
## Key questions: how do we assess that local interfaces and partnerships are effective?

<table>
<thead>
<tr>
<th>Questions</th>
<th>Possible interpretation</th>
<th>Potential Action</th>
<th>Relevant Data and availability</th>
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</thead>
<tbody>
<tr>
<td>Are local people with MH problems able to get and keep accommodation?</td>
<td>Higher rates could indicate good local support to housing providers and provision</td>
<td>Is it clear to housing providers how to access care, training and consultation with senior clinicians?</td>
<td>MHDMS – Accommodation status</td>
</tr>
<tr>
<td>At what rate are people with MH problems in stable accommodation?</td>
<td>Lower rates may question whether housing providers are getting support and if they have the knowhow to access care and therefore prevent people losing their tenancy</td>
<td>Is there a good cross sector commissioning strategy that includes supported housing?</td>
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</tr>
<tr>
<td>Is joint working with the police and magistrates effective?</td>
<td>Higher rates - Are people who are vulnerable engaged in services and their crisis management? Do police have training in diffusing mental health crisis and quick access to support? Lower rates may indicate good street management of mental health crisis and accessing support quickly</td>
<td>Review training initiatives and protocols between police and CMHS</td>
<td>MHDMS – Mental Health Act Event Episode</td>
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<tr>
<td>What is the local rate of use of section 136?</td>
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<tr>
<td>How quickly is an assessment offered to people with MH problems detained in police custody?</td>
<td>Long delays can be detrimental and may also indicate lack of capacity in the system or lack of knowledge as to who to contact</td>
<td>Ensure working protocols and planned capacity with training to custody suite staff</td>
<td>Local data</td>
</tr>
<tr>
<td>Do service users have an effective choice of services?</td>
<td>Large numbers of people with MH problems use local community/voluntary sector org’s and there should be a balance of funding to ensure people can access support before/after specialist interventions or in some cases to prevent pressure on CMHS. Ensure patients and services are aware of what’s on offer.</td>
<td>Regularly review balance of spend and create service directories of voluntary sector. Where there are large providers in the voluntary sector ensure co-ordination between services reduce overlaps and duplication. Smaller organisation will often identify unmet need and should have access to commissioners</td>
<td>Local data</td>
</tr>
<tr>
<td>What is the balance of spend between voluntary sector and statutory sector?</td>
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<tr>
<td>Do local services work effectively with each other?</td>
<td>Where these are not available or too rigid demarcation disputes can occur and patients can often fall between services. Actual practice needs to be monitored against policies.</td>
<td>Ensure that the sum of all operating policies covers all MH need, severity and complexity. Avoid rigid entry points to enable need to be met(not leave people outside of care) but flexibility to move patients between pathways</td>
<td>Local data</td>
</tr>
<tr>
<td>Are operating policies (with entry and exit criteria) for teams/services regularly published and updated?</td>
<td></td>
<td></td>
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<tr>
<td>Are partner protocols published and regularly updated?</td>
<td>Protocols can help partners identify joint working that is to mutual benefit and to the whole community</td>
<td>Is there a forum and system for sharing protocols and jointly agreeing them?</td>
<td>Local data</td>
</tr>
<tr>
<td>Questions</td>
<td>Possible interpretation</td>
<td>Potential Action</td>
<td>Relevant Data and availability</td>
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<tr>
<td>Are there delays in accessing services either beds or to enter specialist teams/services?</td>
<td>CMHS will silt up if high need patients cannot be moved onto more intensive services or specialist teams but equally they need to be able to accept patients stepping down from these services</td>
<td>Consider capacity modelling of individual services and of the whole system where frequent blocks occur. Each component needs to be optimised</td>
<td>DoH KH03 return - Bed Availability and Occupancy – Overnight</td>
</tr>
<tr>
<td>What are the local rates of discharge delay from beds?</td>
<td>Beds are high cost and delays for discharge are costly but also have detrimental effect on patients wanting to go home with support</td>
<td>Ensure have more resources invested in CMHS and compare rates with national benchmarks</td>
<td>DoH Delayed Transfers of care</td>
</tr>
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</table>

**Useful Resources**

<table>
<thead>
<tr>
<th>Document / organisation and Links</th>
<th>Why it is useful</th>
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<tbody>
<tr>
<td><strong>Housing and mental health briefing</strong></td>
<td>Short introduction to the key role of housing and mental health. Useful to CCG members who want to get up to speed quickly</td>
</tr>
<tr>
<td><strong>The Department of Health Voluntary Sector Strategic Partner Programme</strong></td>
<td>Sets out the range of sectors outside of mainstream MH providers who play key part in supporting local communities Help identify the local organisations from voluntary sector who should be involved in MH strategy and some who should be actively interacting with CMHS</td>
</tr>
<tr>
<td><strong>Briefing 36: The Police and Mental Health</strong></td>
<td>Good resource document explaining the problem, strategies and opportunities. Sign posts key statistics and research Can inform if local joint working is tackling the range of factors that police and CMHS face</td>
</tr>
<tr>
<td><strong>Expert guide to direct payments, personal budgets and individual budgets</strong></td>
<td>Personal budgets are a major part of how social care is now being offered and is being extended into health Critical for CCG to understand what progress has been made locally with MH and personal budgets. MH providers need work closely with Social care to ensure MH patients have access to personal budgets to meet social needs</td>
</tr>
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## APPENDICES

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<td>Appendix 3: Data Sources</td>
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</table>
"No Health without Mental Health" (the cross governmental strategy for mental health published in 2011) set out an ambitious plan to deliver improved services for people with a mental illness.

Its 6 key objectives include:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm

"No Health without mental health" built on the previous National Service Framework (NSF) for mental health which had made significant gains in the provision of services to this population. Most notable of these was a broader spectrum of services to support people in the community through a prescribed range of “functional teams”, including community focused crisis services, assertive outreach and early intervention for some of the most serious and life threatening illnesses.

The impact of these changes is an acknowledged reduction in bed use and therefore more choice and care in lesser restrictive conditions [http://www.ic.nhs.uk/catalogue/PUB10347](http://www.ic.nhs.uk/catalogue/PUB10347). It has also led to improved outcomes and experiences for service users.

The strategy and the subsequent clarifications issued in the Implementation Framework marked a further move away from some of the approaches typified by the National Service Framework (NSF). The NSF had promoted a concept of “fidelity” and ensured the development of specific services such as specialist community teams following clearly prescribed models and supported this with a prolonged period of investment. The new strategy focuses on outcomes and the broader determinants of mental health, is less prescriptive and of course takes place in a much changed financial and commissioning environment.

In these changed circumstances many trusts have begun to re-organise / transform their community teams. Typically, this has led to attempts at simplifying assessment and pathways to services and combining the functions of some of the previous specialist teams.

**Key question**

Against this background, how does the CCG decide what to commission and how does it know what it commissions is effective?
Clinical Commissioning Groups

The new commissioning arrangements now established mean that the bulk of mental health services and all of community mental health services will be commissioned by Clinical Commissioning Groups (CCGs).

This represents an unparalleled opportunity to develop models of care and pathways that will meet current and future needs of local populations for whom CCGs are responsible. It also provides a significant challenge.

CCGs have begun the shift to focus on two key objectives:

- The reduction of health inequalities, from the perspective of both access and health outcomes;
- And on an overall improvement in primary care provision

Each of these will result in a need for the CCG to reappraise MH provision.

CCGs will be setting out their strategic objectives and in priority areas asking critical questions of current service provision. Experience tells us that MH is often viewed as too difficult or different to deal with in a systematic way. A long legacy of block contracts and late entry to policy initiatives such as Payment by Results (PbR) have left decision makers, in particular commissioners with little meaningful data on which to test performance of providers and reach conclusions on what represents good performance. Obtaining data and achieving consensus in MH can still feel like a maze and CCGs will need to navigate a diversity of opinion, authority and interpretation on data to reach firm conclusions on MH strategy.

WHY COMMISSIONING GOOD MENTAL HEALTH SERVICES IS A PRIORITY

Prevalence and Cost

Mental health problems are common and rising; studies estimate that the proportion of the English population meeting the criteria for one common mental disorder has increased from 15.5 per cent in 1993, to 17.6 per cent in 2007. Among people under 65, nearly half of all ill health is mental illness and at least one third of all families (including parents and their children) include someone who is currently mentally ill. Depression and anxiety disorders are the most common forms of mental health problems, and evidence indicates that around a third of people with depression and half of people with anxiety disorders do not receive any support or treatment from health services.

Even though the prevalence is high the level of need identified and then met through a statutory service is low.

Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability. The cost of mental ill health in England is £105.2 billion a year and treatment costs are expected to double in the next 20 years. This figure includes the costs of health and social care for people with mental health problems, lost output in the economy, for example from sickness absence and unemployment, and the human costs of reduced quality of life. Mental ill health carries a heavy cost, especially for those who experience mental health problems and their families. It costs businesses

1 HOW MENTAL ILLNESS LOSES OUT IN THE NHS a report by The Centre for Economic Performance’s http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf
more than £1,000 for every person they employ and has an impact on spending in every government department. Mental ill health is a fact of life. Every day, one in six of us experiences mental ill health, while one in 100 has a severe mental illness. It is vital that government, public services, businesses and communities respond well to mental ill health and do their bit to prevent both distress and discrimination.

Spend
It’s important because we spend a lot on it. Total investment in working age adult mental health services in 2010/11 was £6.550 billion or £195.8 per head of weighted working age population. This represents a cash increase of 3.6% on the previous year and a real increase of 0.7%. For further information on mental health spend at a PCT level click here.

Economic appraisal / impact
In 2008/9, the NHS spent nearly 11% of its annual secondary healthcare budget on mental health services, which amounted to £10.4 billion. Estimates of the cost of different mental disorders across the life course in England have been made for example: depression £7.5 billion, anxiety £8.9 billion, schizophrenia £6.7 billion and dementia £17 billion.

Physical health and mental health
Improving mental health helps improve physical health. There is substantial overlap between mental and physical illness. Around 30 per cent of people attending general practice have a mental health component to their illness. Many people with long-term physical health conditions also have mental health problems not only leading to significantly poorer health outcomes but also higher health care cost. By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.

   The economic case for improving efficiency and quality in mental health
What Service Users tell us they want from Community Mental Health Services?

In recent years many studies and documents have highlighted the importance of service user experience and the need to improve the experience. Most recently, the Picker Institute Europe which specialises in reviews of patient experience has set out service users requirements into eight dimensions, divided into two sub-headings:

1 The relationship between individual service users and professionals:
   - Involvement in decisions and respect for preferences
   - Clear, comprehensible information and support for self-care
   - Emotional support, empathy and respect.

2 The way that services and systems work:
   - Fast access to reliable health advice
   - Effective treatment delivered by trusted professionals
   - Attention to physical and environmental needs
   - Involvement of, and support for, family and carers
   - Continuity of care and smooth transitions.

In response NICE have developed a guidance (CG136 Service user experience in adult mental health) which offers advice on improving the experience of care for people using mental health services in the National Health Service.
## Useful Resources – General

<table>
<thead>
<tr>
<th>Document / organisation</th>
<th>Why it is useful</th>
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<tbody>
<tr>
<td>No health without mental health , 2011</td>
<td>National mental health strategy 2011 sets out context, rationale and impact on populations’ health by providing public health, primary care and specialist services. Appendices provide key information for instance on economic impact of mental health spend.</td>
</tr>
<tr>
<td>Mental health network factsheet 2009</td>
<td>Key facts and trends in Mental Health</td>
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<tr>
<td>How Mental Health Loses out in the NHS, June 2012</td>
<td>Understand the priority needed in commissioning mental health services</td>
</tr>
<tr>
<td>CQC Community Mental Health survey</td>
<td>Provides a benchmark on service performance and quality. Can enable you to judge local services in a performance context</td>
</tr>
<tr>
<td>Mental Health Public Health observatory</td>
<td>Collects data on mental health and has expertise and authority in public mental health matters</td>
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<tr>
<td>Long-term conditions and mental health, The cost of co-morbidities</td>
<td>Review the available evidence on the interaction between mental health and long-term conditions and consider examples of innovative practice from the UK and abroad to combat the problems associated with the co-existing conditions.</td>
</tr>
<tr>
<td>MH financial mapping</td>
<td>Provides context to spend overtime and helps make benchmarked comparisons of spend which can then be compared to the levels of services provided.</td>
</tr>
</tbody>
</table>
• It is important to recognise specialist community services care for a range of severity of illness and that some patients require care under provisions of the Mental Health Act 1983/2007 and Mental Capacity Act 2005. This places statutory responsibilities on Commissioners to ensure that services are sufficiently staffed and resources to fulfil the legal requirements of this legislation.

• It is likely that future commissioning of mental health services will be shared between Clinical Commissioning Groups, NHS Commissioning Boards, Local Authorities, and Public Health England. These will therefore be responsible, in whole or part, for a number of statutory responsibilities that arise from the Mental Health Act (MHA) and Mental Capacity Act (MCA):

  • After-care services for mental health patients and direct payments (s117, MHA)
  • Power to discharge NHS patients from detention in independent hospitals and authorise visits (s23/s24, MHA)
  • duty to provide court on request with information about availability etc of hospital places (s39, MHA)
  • duty to make arrangements for independent mental health advocates (IMHAs) to be available to qualifying patients (s130A, MHA)
  • duty to notify local social services authorities of availability of suitable hospital places for emergency admissions and for under 18s (s140, MHA)
  • Duty to consult an Independent Mental Capacity Advocate (s37/s38, MCA).
### APPENDIX 3: DATA SOURCES

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<tr>
<th>Data Source and Link</th>
<th>Data Description</th>
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| **Joint Strategic Needs Assessment (JSNA)** | JSNA's analyse the health and social needs of local populations to inform joint health and wellbeing strategies. These in turn inform commissioning of health, wellbeing and social care services in a local authority. A JSNA data set provides powerful indicators to establish current and future health needs of your local population. This in turn, supports better targeting of interventions to reduce health inequalities.  
Since mental disorder and wellbeing have such a large impact across a wide range of outcomes. A JSNA requires relevant information about mental disorder and wellbeing including:  
- Level of risk factors for mental disorder and protective factors for wellbeing across the local population, including levels of inequality  
- Numbers from different local population groups at higher risk of mental disorder and low well-being who benefit from prevention and promotion interventions  
- Local levels of mental disorder and well-being including from groups at higher risk (numbers affected)  
- Assessment of unmet need  
- Proportion of the population with mental disorder receiving intervention including from high-risk groups  
- Proportion of population receiving promotion and prevention interventions who would benefit from such intervention including from high-risk groups  
- Local economic impact of investment in interventions to treat mental disorder, prevent mental disorder and promote mental health  
- Assets assessment: Joint Strategic Assets Assessments (JSAA's) augment JSNAs and identify the assets available in an area to improve health and social outcomes. These may include the quality and accessibility of services, evidence about what works locally, and the views and experiences of the public.  
- Information about the impact of mental disorder and wellbeing on other JSNA priority areas |
| **Secondary Uses Service (SUS)** | The Secondary Uses Service (SUS) is primarily a data warehouse that provides access to anonymous patient-based data for purposes other than direct clinical care such as; healthcare planning, commissioning services, public health and national policy development  
SUS is delivered by The NHS Information Centre and NHS Connecting for Health. It contains up-to-date data on all hospital episodes, a rich source for benchmarking and trend analysis by condition, procedure, referring GP, patient type etc |
<p>| <strong>GP Practice Records</strong> | Detailed intelligence on patient activity, referrals and prescribing practice in particular. |</p>
<table>
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<tr>
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| **Quality Outcome Framework** | Indicators of GP performance in four domains: clinical, organisational, patient experience and additional services.  
- Clinical indicator groups: The 6 Mental Health indicators  
  - The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses  
  - The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the previous 15 months  
  - The percentage of patients on lithium therapy with a record of lithium levels in a therapeutic range within the previous 6 months  
  - The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate  
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by practice team within 14 days of non attendance  
  - The percentage of patients with schizophrenia and bipolar affective disorder and other psychoses with a review recorded in the previous 15 months. In the review there is evidence that the patient has participated in routine health promotion and prevention advice appropriate to their age and health status |
| **The Mental Health Minimum Dataset (MHMDS)** | Is an approved NHS Information Standard that delivers robust, comprehensive, nationally consistent and comparable person-based information on people in contact with specialist secondary mental health services. It is unique in its coverage, because it covers not only services provided in hospitals, but also in outpatient clinics and in the community, where the majority of people in contact with these services are treated. The indicators include:  
- the number of people using NHS mental health services  
- the rate of access to NHS mental health services by 100,000 population  
- the number of people detained in hospital  
- the number of people on the Care Programme Approach (CPA)  
- information about how long people spend in hospital  
- information about the number of beds, patient admissions and discharges  
- number of contacts with different professional staff groups  
- information about types of clinical teams coordinating patient care |
| **Community Mental Health Survey – CQC and DoH** | The latest National Statistics on the patient experience survey, produced by the Department of Health and the Care Quality Commission. The statistics use responses that NHS patients gave in the wide-ranging National Patient Survey Programme to calculate a set of scores to measure patient views on the care they receive. |
| **DoH – Hospital Activity Data**  
Quarterly Activity Return (QAR) | Inpatients (electives only)  
- Decisions to admit  
- Patients admitted  
- Patients failed to attend  
- Removals other than admissions  
Outpatients  
- Number of GP written referrals  
- Number of other referrals  
- 1st attendances seen  
- 1st attendances did not attend  
- Subsequent attendances seen  
- Subsequent attendances did not attend |
<table>
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<tr>
<th>Data Source and Link</th>
<th>Data Description</th>
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</table>
| MH Community Teams Activity Data | Number of new cases of psychosis served by Early Intervention teams (YTD)  
Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (QA)  
Total number of patients on CPA discharged from psychiatric inpatient care (QA)  
Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (QA)  
Number of admissions to acute wards that were gate kept by the CRHT teams (QA)  
Total number of admissions to acute wards (QA)  
Proportion of admissions to acute wards that were gate kept by the CRHT teams (QA) |
| NHS IVIEW | • Staff-In-Post (Headcount, FTE, Assignments)  
• Staff Earnings (Total Earnings, Basic Pay)  
• Sickness Absence (FTE days available and lost per month, Absence Rate)  
• Staff Turnover (Headcount, Joiners, Leavers, Stability Index)  
The data can be broken down in many ways such as place of work; occupation; Agenda for Change band; gender; age and ethnicity. Trusts and SHAs can easily compare their workforce information with similar organisations. |
| NHS Staff Survey | The NHS Staff Survey is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input into local and national assessments of quality, safety, and delivery of the NHS Constitution.  
Includes questions on Mental health specific training, learning and development |
| DoH KH03 Return Bed availability and Occupancy | The KH03 is a quarterly collection from all NHS organisations that operate beds, open overnight or day only, both NHS Trusts and PCTs. It collects the total number of available bed days and the total number of occupied bed days by consultant main specialty. Prior to 2010-11 the KH03 was an annual return collecting beds by ward classification. It also included data on Residential Care beds. |
| DoH Delayed Transfers of Care Information | Data on the number of patients delayed on the last Thursday of each month and the total delayed days during the month for all patients delayed throughout the month. |
Please get in touch...

Should you require any further information, please do not hesitate to contact:

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