MANCHESTER
CITY COUNCIL

NHS

North, Central and South Manchester
Clinical Commissioning Groups

Mental Health Improvement Programme
Engagement Report 2014

Parveen's Journey in the Anxiety Care Pathway

I started to feel really jittery at work and was anxious all the time. Going to work became a nightmare and I felt as if I was having a heart attack on some days. I had to go off sick because I felt so ill. My heart would race. I would have difficulty breathing. I felt panicked

I went to my GP and he did some tests and asked me about what was going on in my life and reassured me that my heart was strong and I was not at risk of a heart attack

My GP referred me for an assessment for some ongoing support. They gave me lots of helpful information about managing my anxiety and I had a course of CBT. Gradually I started to feel more in control and less anxious

The worker also gave me some self help information so I joined a walking group and even though I couldn't go every
week, it really helped me to rel
new friends and seen parts of
before

I have now returned to work
full time. My manager knows
know if I am feeling anxious ra
worse

Stephen's journey in the Psychotic Crisis Care Pathway

Stephen has been known to mental health services since he was 20 following a number of presentations at A&E after cutting his arms and wandering onto a railway line. At a number of assessments he said that he had heard voices telling him that he was a bad person and he calmed himself down by smoking cannabis and drinking and this made him feel better. He refused to attend regular appointments and was 'sofa surfing' at friends' houses and living in a number of hostels. He was known to community drug and alcohol services and he often slept rough. He refused to engage with services maintaining that they were trying to control him and he wanted to be left alone

When Stephen was 22 he was brought to A&E on a Section 136 after he had started shouting, during a fight in the homeless hostel he was living at, that voices were telling him to hurt himself and other people. He was assessed in A&E and admitted under a Section 2 to an acute inpatient psychiatric bed in North Manchester. During his admission he was stabilised onto a medication regime but he reported that he missed drinking and smoking cannabis

After 8 weeks on the ward he was stable on his medication and had some insight into identifying when his symptoms were returning. He was referred to the early intervention in psychosis team who allocated a care co-ordinator who met with him to agree a care plan. The problems identified were his drug and alcohol use and that he had no stable accommodation in the community. Stephen agreed to be referred to a shared house that had
floati
health support input and he was allocated a worker from the
nd alcohol team who met with him before discharge from
t his expectations from the service

ttled into his accommodation quickly and was building
g men in the project. When he was first discharged he
e a week to talk about his strengths and weaknesses
6 months he had a number of panic attacks following
nts but he then began to spend time
share with him their experiences of
opportunities they had been able
is but still uses it when he feels
rk with him to identify his stress

ow working with his
due to his medication.
in the next 12 – 18

Ian's journey in the ASD Pathway

Throughout school and university I always struggled to make new friends and often felt 'out of place' in new social situations. Some people have commented that I can be rude and abrupt with them and do not understand humour. I dropped out of university and since then I have only been able to get a number of short term jobs doing data in-putting. A couple of my managers commented on how thorough my work was, but that I could not manage changes to my work patterns, and did not socialise with my work colleagues. I still live at home and my mum is becoming very frustrated at how much prompting she needs to give me to get me to do tasks in the house

My mum read an article at work about adults on the autism spectrum and how once they had a diagnosis they could access additional support in education and employment. We agreed that I had many of the symptoms that were in the article and decided to look for support for a diagnosis

I made an appointment with my GP who asked me to complete a pre-assessment questionnaire, which I did and, from that information, the GP agreed to send a referral. Two weeks later I got an appointment letter confirming the date and time of my appointment

Following this assessment I was given a diagnosis of high functioning autism and they discussed with me the range of support I could access from the National Autism Society and Job Centre Plus. I am thinking of going back to university to complete my course as there is significant support that the University Disability Service can offer

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Background and why we were engaging

This report details the engagement programme undertaken to support North, Central and South Manchester's Clinical Commissioning Groups' Mental Health Improvement Programme.

It also includes a summary of the engagement feedback from Manchester City Council's health and well-being consultation.

The engagement programme ran from the first public release of the Mental Health commissioning intentions document on 24th July 2013 to the final public engagement event on 4th February 2014 and subsequent closure of the online survey the following day.

Alongside dedicated web pages and two online surveys, our engagement programme saw partners across the city working closely to make sure that we involved as many people as possible and particularly those who these changes would affect most.

- We worked with Macc to develop a 'facilitation offer' so that local groups could work with independent local facilitators to plan, run and report on over twenty bespoke engagement events.
- We worked with HealthWatch Manchester and their volunteers to run awareness raising market stalls in partnership with the Manchester stop smoking service who kindly let us use their existing stalls.
- Macc also worked with independent patient and advocacy groups to research and develop a draft patients' charter that reflected the needs and wishes expressed by patients and carers in the city over recent years.
- Alongside the public engagement work, the Mental Health Improvement Team facilitated a number of clinical engagement events to enable local clinicians to be involved in the development of care pathways.
- We worked closely with Manchester City Council to ensure that our work was as closely aligned as possible with their mental health and well-being consultation.

Since launching our public engagement programme in November 2013 we have engaged with 259 healthcare professionals and over 370 patients, carers and members of the public, with a further 470 people giving their feedback in the City Council's consultation. In doing so, we have received detailed feedback from local people, patients and carers about what they want local services to achieve for them.

All of this feedback was passed on to Mental Health Strategies, an independent organisation that have with commissioners use this information to developed the final care pathways and service specifications, so that these can reflect what local people have told us they want and need from a new mental health system for Manchester.

Our mental health and well-being plans for Manchester

The document setting out the commissioning intentions for Manchester's mental health and well-being system was submitted to the July 2013 public boards of each of the three Manchester Clinical Commissioning Groups. The paper was added to the Talking Health Manchester website along with a copy of Mental Health Strategies independent report.

A short online survey canvassing people's opinions of the proposed move towards outcomes based commissioning was set up and a press release was written to direct people to the documents and survey. This was released on 24 July 2013 and was promoted by a range of partners and organisations including Survivors Manchester, the Manchester Cultural Partnership and the Health Service Journal included it in as a local analysis article.

In total, 72 people responded to the survey. Of these, 12 represented organisations while 60 responses were received from individual patients, carers and members of the public.

Over 79% of respondents (n=52) agreed that the proposed approach was the best one, however nearly half felt that there were things that the proposals had not covered.

Respondents who did not agree with the proposals raised concerns about:

- the level of funding available to make real change
- the potential negative outcomes of a lead provider approach
- the likely effectiveness of an outcomes based approach work with mental health conditions (eg with alcoholism, dementia or Parkinson’s)

Respondents suggested that the following items had not been covered in the proposals:

- Carers
- Accessibility of psychiatrists and acute inpatient beds
- Support for families following suicide
- Clear links with housing providers and homelessness services
- Sufficient emphasis on diversity
- A rapid response service and proposals to harness new technology in service delivery

Respondents were also asked for their suggestions on how to improve services they had used recently - their recommendations included:

- Better referral process from one team to another, more collaboration
- Shorter wait times and issues with limited access
- Improving public and GP information about availability of services
- Change culture of poor quality assessment
- Continuity of care
- Less reliance on medication
- Need easy access to 24/7 crisis service

Results from this survey were fed into Mental Health Strategies' work in developing the proposed pathways. Before the wider public engagement on the proposed pathways could be launched, they were further tested at two events.

An event for voluntary and community sector representatives to explore the commissioning intentions was held at the Friends' Meeting House on 29th August 2013. Nine local organisations were represented by 11 attendees.

Questions were raised about the engagement process, GP knowledge and training, integration, protecting the creativity and responsiveness of the voluntary sector, number and availability of acute beds, service clustering, managing acute crisis in the community and the importance of including patient experience.

A further event for patients and carers was held at the Friends' Meeting House on 1st October 2013. 19 people attended and took part in a plenary sessions followed by group discussions looking in more detail at four of the proposed pathways.

- Table 1 focused on depression – comments received included:
    - The need to be more focused on prevention and promoting well-being
    - Pathways are fragmented, need coordination
    - Need to actively encourage user engagement and show empathy
    - Move from care plans to person centred plans
    - End to multiple assessments

- Table 2 discussed the care pathway for common mental health problems with long-term physical problems – comments included:
    - GPs need more training
    - More mental health workers in GP practice
    - GPs aren't informed enough about mental health
    - A handbook is needed of physical and mental health services
    - Whole-person approach – all practitioners should take this approach
    - Drop-in centres – recovery hub at Park house underused
    - Respite facilities needed – example would be on anniversary of death - intensive extra support needed temporarily
    - Crisis / turning point facilities
    - Family support / support for carers (confidential)
    - Mental health and physical health services don't work together or communicate
    - GPs confusing physical and mental health
    - GPs need more time
    - Discharge from recovery services without follow-up
    - Rapid response for psychological therapies in conjunction with medications.

Positive comments included support for service user groups and voluntary and community sector services; some crisis services although not those of the trust; Individual budgets; referral onto other professionals but only from within services.

- Table 3 looked at the care pathway for psychotic crisis (including management of section 136 Mental Health Act 1983). Comments included:
    - Referral into services should not just be via GP
    - Look at having crisis centres in the community
    - Having an assessment should be early in the discussion with patient and must include discussion of medications and side-effects
    - Need to be up-skilling frontline professionals notably police and housing
    - In-patients need to access user engagement and advocacy
    - Care Programme Approach (CPA) should be able to happen closer to home
    - Impatient beds in central Manchester are needed
    - Staff should be trained in cultural and religious needs

- Table 4 talked about the care pathway for non-psychotic mental health problems in 16-17 year olds. Comments included:
    - Very positive response to system
    - Early identification
    - Humanistic person centred holistic approach is needed
    - Shared responsibility is very good idea but could get in the way
    - Transition to be managed by the Child and Adolescent Mental Health Services (CAMHS)
    - Information is patchy, advocacy would be helpful

Results from these events were fed into Mental Health Strategies' work in developing the proposed pathways.

Engagement steering group

A Mental Health Improvement Programme engagement steering group was set up at the beginning of October 2013 to develop partnership working and co-production arrangements and to guide the development of the main public engagement work.

Membership of the group included:

- Nick Gomm, Head of Corporate Services, NHS North, Central and South Manchester CCGs
- Julian Palfreyman, Communications and Engagement Manager, Greater Manchester Commissioning Support Unit
- Nigel Rose, Strategic Commissioning Lead, Macc
- John Butler, Development Worker, Macc
- Neil Walbran, Chief Officer, HealthWatch Manchester
- Linda Colgan, Programme Lead, Mental Health Improvement Programme, Citywide Commissioning Team , NHS North, Central and South Manchester CCGs
- James Fitton, Director, Mental Health Strategies
- James Stock, Commissioning Manager, Manchester City Council

The group met on a weekly basis in the run up to the launch of the public engagement programme. During this time, the group agreed that feedback should be linked to the 17 care pathways that had been identified as a result of the work around the commissioning intentions. Other key decisions included:

- Developing a 'facilitation offer' for local voluntary and community sector organisations to access via Macc. This involved inviting local organisations to express their interest in facilitation support, retaining and briefing independent professional facilitators, setting up reporting mechanisms, agreeing funding and payment arrangements to engage independent facilitators to help local organisations to develop, plan, deliver and report on their own bespoke engagement activities.

  4 specific questions were developed for facilitated sessions:

  1. The proposed system has 17 care pathways which show the services that will be available to people with different mental health needs. Are they the right pathways or do some need to be separated or merged? Is there anything we have missed?
  2. We want to measure how well services are doing based on “outcomes measures” (what they achieve for patients) instead of an “activity” (the number of appointments to see someone, or days in hospital they provide). Do the specifications ask the right outcomes? Are we measuring the right things? Is there anything that you would do differently?

3. We know that good mental health care often needs difference organisations to work together well. We want services to work together so that everything is well co-ordinated. What are the critical things that services need to do make this possible? Is there anything that services should not do?
4. We may use outcome measures to set financial rewards or penalties for service providers. Which outcomes are most important to you?

- Comment and approval of the public engagement plan, web content, copy, website design, leaflets, promotional materials, number, dates and nature of public events.

- Development, comment and approval of the main engagement questions, survey and methods of collecting responses.

- Agreeing partnerships between represented organisations, co-promotion and collaboration.

- Alignment of public engagement with Manchester City Council who planned to consult on their mental health and wellbeing offer at the same time.

  Unfortunately, timescales were not a precise match and so the two pieces of work could not be merged. When it became clear that it would be impossible to create a single overall exercise, partners worked closely to ensure that the two separate processes were as closely aligned as possible to maximise efficiency and minimise duplication.

- Development of a planned programme of awareness raising market stall type events in partnership with HealthWatch Manchester.

- Macc-led review of existing responses, evidence, reports and submissions leading to development of a service-users' charter. Macc representatives were very much aware that consultations and engagement exercises around mental health provision have occurred fairly regularly throughout recent history. Macc agreed to lead on a systematic review of responses from local voluntary and community sector organisations to establish key themes that would form a draft service-users and carers charter and could inform the development of service specifications.

- Macc-led development of an independent forum representing patients, carers, their advocates and representative groups from across the voluntary and community sector in Manchester. Independent service-user forums have been successfully developed in the past but have ceased to function over time. Macc noted that the Mental Health Improvement Programme in Manchester is likely to create sustained and significant change that an organised and independent service user voice could potentially influence.

Engagement on the proposed clinical pathways

Macc facilitated engagement events

22 individual supported engagement events were held with a range of groups across the city.

The targeting of resources ensured a good spread of representation across the pathways from various areas of the city and their diverse groups, cultures and communities of interest.

- African and Caribbean Mental Health Services
- Black Health Agency
- Respect for All/National Autistic Society
- Children's Society
- Ethnic Health Forum
- Europia
- Lesbian and Gay Foundation
- Manchester Settlement - Social Group meeting
- MC-uk
- Manchester Refugee Support Network
- Manchester Users Network
- North Manchester Black Health Forum
- The Rusholme Film Club
- Self Help Services - The Sanctuary
- South Manchester Users Group
- SPICE- a local partnership in Harpurhey
- Survivors Manchester
- The Men's Room
- Turning Point
- Wai Yin
- Manchester Carers Forum (Dementia pathway)
- Manchester Carers Forum (Psychosis pathway)

Macc engaged 5 independent facilitators to work alongside the host organisations in the planning, facilitation and report writing. This was intended to provide the host organisations with extra capacity; reassure commissioners as to the accuracy of the findings and; provide some consistency in approach.

250 people from diverse communities participated in these events, many of whom had not been involved in engagement events like this before.

While some expressed reservations about the outcomes of the exercise most were very grateful for the opportunity to get their voices heard; were keen to find out about the impact of their involvement and; wanted further involvement going forward.

A separate Macc engagement report on these activities is available on request from John Butler by email John@macc.org.uk or by telephone on 0161 834 9823.

Mental Health Strategies have undertaken detailed analysis of the feedback and comments received through the Macc facilitation process. This has been presented along with details of which recommendations will and will not be included in the development of specifications. This information can be found on page 34 to page 48.

We have below, included the questions asked at the engagement events and some of the feedback we received from all of the 22 groups:

1. **The proposed system has 17 care pathways which show the services that will be available to people with different mental health needs. Are they the right pathways or do some need to be separated or merged? Is there anything we have missed?**

A holistic approach

- There needs to be a holistic approach to people with mental health problems including issues such as culture, spirituality and lifestyle

- Participants wanted to have their needs met as whole people and not have to access different services all dealing only with part of their needs. They also felt there was a mistaken tendency to focus on their LGB identity as a specific "cause", almost underlying the anxiety or depression with which many LGB people present. Such an assumption is not helpful. Mental health professionals need to understand that while overt or internalised homophobia or bi-phobia may affect someone's mental health, the person's sexual orientation is not in itself the cause.

- Participants were concerned that the pathways might be problematic when someone had more than one condition. One woman, for example, had a son with ADHD who was also depressed. ‘Which pathway would he be treated under?’ ‘Would he get the best care if he had more than one condition i.e. if treated under ADHD pathway would the staff have the best knowledge/ experience for treating depression’?

- The participants were not familiar with the mental health pathways and conditions requiring further explanation and examples. It was commented that the pathways are too prescriptive and difficult to relate to everyday life. Instead people think in terms of their situation, life-stages and personal symptoms, “the fear of being alone in the house, every sound is frightening” rather than labels.

- Participants thought there was cross-over between the different pathways particularly with depression and psychosis conditions, with people experiencing similar symptoms. It was argued there needs to be recognition of dual diagnosis particularly with an increase of people using alcohol and drugs as a way to cope with mental health conditions, often resulting from not being able to access appropriate mental health services.

- Schizophrenia, depression, bi-polar were among key concerns. While social isolation might not be a pathway in its own right, it was clearly a major contributor to a number of other problems.

- There was concern that the way the pathways were structured resulted in putting people in categories which would work against people being properly listened to, for their condition may cover several pathways. An example was given of someone with dementia who was also depressed Participants felt it was very important for them to be treated holistically rather than as someone who had a particular condition.

Responsiveness

- When HIV is caught on at an early stage, the treatment of HIV may only cover one pathway, however, when someone is diagnosed at a late stage of HIV infection, they are more likely to need different pathways for treatment.

Potentially excluded communities

- Asylum seekers and refugees are afraid to get registered with GPs out of fear of being deported so they feel like they can only access wellbeing services.

- They commented that a lack of understanding about Autism, Asperger's, ADHD and learning disabilities was apparent throughout frontline services and they felt that training for frontline staff was inadequate.

- The discussion focused around two concerns: pathways reflecting the refugee experiences of mental health and cultural considerations. Refugees have mental health needs and conditions that may not be common to the wider community related to their experience of displacement, resettlement and extreme violence. It was advocated that his should be included in the pathways as a specific condition.

Promotion of services

Young people shared they had had a mixed response to their mental health needs and many were not aware of the services available to them, had not been referred or had found alternative sources of support.

Diagnosis

The group also felt it was important to try and discriminate between different pathways in terms of which pathway actually constituted the real cause of the problems and which was the effect. So sometimes people came presenting problems to do with alcohol abuse which were in fact to do with anxiety.

Choice

Participants also discussed the importance of being offered choice when accessing services. Different individuals have different needs and a one-size-fits-all approach will be unlikely to succeed. For instance, while drug treatments might work for some people members of the group felt that often drugs were being prescribed because this was a cheaper option in the short-term in comparison to offering psychological treatments, even though they are more effective in the longer term.

Gaps

Specific issues which seemed to fall outside the pathways included: treating deliberately risky sexual behaviour, self-image and confidence, social isolation and socio-psychological issues.

Challenges

- There were concerns that the pathways represented a scale of severity or importance of mental health conditions and this is too prescribed and simplistic.

- The discussion was about the complexity of mental health for survivors of sexual abuse and rape, the need for descriptive dual diagnosis and a combination of treatments. It was argued that prescriptive pathways don't address the underlying-causes of the problem, instead focusing on symptoms, resulting in referrals to inappropriate or poorly sequenced services.

- All the carers agreed that dementia should be a separate pathway because it is a separate disease.

2. **We want to measure how well services are doing based on "outcomes measures" (what they achieve for patients) instead of an "activity" (the number of appointments to see someone, or days in hospital they provide). Do the specifications ask the right outcomes? Are we measuring the right things? Is there anything that you would do differently?**

Diagnosis

- Better assessments and early diagnosis (the process of assessment, for Asperger's in particular, was felt to be too complex and arduous. It is difficult to get funding for an assessment and people have to travel to Sheffield for the assessment and post assessment support. Diagnosis is often too late and delays in diagnosis can lead to long term mental illness and, in some cases, crime or substance misuse that have long term negative impacts on the person's life.)

Outcomes

- Social outcomes need to include improvements such as participating in activities, being able to cope with going shopping, being able to leave the house, controlling debt, sexual health, how much people feel in control of their own lives and whether they are able to make decisions for themselves.

- People felt that the outcomes should be personalised and people should set their own goals. The provider should be assessed on a staged/stepped approach where people move towards achieving the goals they have set.

- The men identified the following outcomes as important: Help to recover from addiction and to access interventions, activities and talking support that would help them remain substance free (health outcomes), using medication when necessary, not to make people easier to manage (health outcomes), talking therapies important to help people understand the underlying reasons for their addiction

- Primarily and vital, any outcomes should be under-pinned by respect and dignity for the patient as a person. The important outcomes can be categorised as addressing basic needs including safety, feeling useful and realistic recovery goals resulting in the overall aim of less hospital admittances and length of stay.

Underlying issues

- Better awareness of the issues causing depression among African communities.

- Achieving satisfactory outcomes is linked to receiving treatment that is appropriate to the individual and culture.

Carers

The importance of including the outcomes for carers was also stressed In terms of indicators of a good service in the future, participants stressed the need for.

Support

- There is a need for ‘floating support’ that is responsive to the unpredictable nature of mental health conditions with people needing rapid and timely interventions to prevent the condition worsening.

Workforce issues

- Currently there are risks to both patients and staff due to long shifts with unhealthy rotas, low pay and lack of management support. Too much pressure is put on staff and they become intolerant. The zero tolerance policy towards violent, aggressive and abusive behaviour within the NHS can be misused when people have been working long hours and have lost their tolerance as a result.

3. **We know that good mental health care often needs difference organisations to work together well. We want services to work together so that everything is well co-ordinated. What are the critical things that services need to do make this possible? Is there anything that services should not do?**

Cultural sensitivity

Services should not assume that all people are the same and that cultural differences don't exist/matter. Do not expect that a half day training course in cultural issues is sufficient.

Process

- More reviews involving individual service users, to ensure good progress monitoring.
- Care coordinators should liaise with employers to help the person maintain employment.
- There needs to be a focus on prevention rather than crisis with early intervention and health focused services, not illness focused
- Practitioners should have more autonomy to meet the patient's needs - patient responsive outcomes and a patient centred approach.

Support

- Advice and Guidance with practical and health issues so that young people feel that there are solutions and opportunities for them to improve.
- Peer support and advocacy is very important, provided by local community organisations, to help with people reluctant to share their condition and obtain support from their community and friends.
- The service should not decrease the number of CPNs active in the area of mental health-they are a very cost effective way of keeping people in the community and much valued.
- There should be an option for community-based therapy at a place where patients feel safe and this should be available outside working hours. It was strongly expressed that this should remain NHS regulated and endorsed.
- Services should make full use of community facilities-they can provide a very cost effective way of provided structured activities in an informal setting.

Access

- Free services, as have very limited finances
- Services should not make people have to travel for treatment. It can be very stressful for the patient and the family. This can also increase the sense of isolation.

Internal issues

- They need to demonstrate respect and not demonstrate an over-enthusiasm for "clock-watching".
- Different services need to co-operate together at each stage of the process i.e. when the service contract is being devised, when the services are being planned, when they are being delivered and when they are evaluated.
- In relation to treating the underlying causes and contributing factors to mental health, and the aim of leading a full-life, it is important for mental health services to link with community services.
- People felt that services took a high pressure sales approach which involved ticking boxes and reaching numerical targets.
- There needs to be more communication between all the different parts of wellbeing and mental health services.
- There is no acknowledgment that patients may not give full information and carers are not included in discussions enough in some cases, although their experiences were mixed and one person did feel she was consulted enough.
- Providers cite confidentiality as a reason they cannot share the content of discussions with the patient, with the carer.
- Professionals sometimes have preconceived ideas about the person's background and have an attitude of blame (this was a comment from the parents of children with psychosis/substance misuse).

4. We may use outcome measures to set financial rewards or penalties for service providers. Which outcomes are most important to you?

Outcomes

- Having a sense of belonging and dealing with solitude.
- Important outcomes included feeling respected with less judgements and stereotypes; a shift to a holistic approach to wellbeing and mental health, correct diagnosis and support to lead a full-life.
- Having basic needs met, creating a feeling of security that enables recovery.

- The important outcomes for survivors of sexual abuse and rape are the need to disclose their experiences as a first step to addressing the underlying causes of mental ill-health, improving their emotional competencies as a route to recovery leading to feeing safe and secure.

- Service users particularly valued interventions which made them feel in control, able to consider the consequences of their actions, able to feel more in control, to manage their relationships with their families, especially to take responsibility for care.

- Carers Outcomes to be included within all the outcomes and throughout the specifications.

Measurement

- Both increase in mental health AND decrease in mental distress should be used as outcome measures. Most important outcome measures include increasing self-esteem, reduced dependence on alcohol and drugs, greater understanding about self-help in mental health but also access to services when that is needed.

- The group did not choose one outcome as being more important than another but did say that there should be flexibility around the penalties so that the service provider is not tempted to make the data fit to avoid penalties. The provider needs to feel safe about being honest about their ability to achieve outcomes and needs to be encouraged to be honest, open and transparent about their performance.

5. **Please tell us about any other aspects of the discussion that have not been recorded above. For example, differences of opinion; points or stories that were especially relevant or particular views that were promoted (or suppressed) by the group?**

Groups with unique issues

- The group wanted to know where Asperger’s fits within the new mental health services as it is missing from the pathways and currently, support is minimal. Many people have multiple diagnoses and services are unable to support this at present.

- This group of young people have suffered traumatising experiences in their home countries, on their journey to the UK and have then arrived to a place of presumed safety, which is in fact an alien place of uncertainty and disbelief. All of the young people expressed that the stress of arriving and living in the UK have negatively affected their mental health. Consequently, for these young people their mental health and well-being are inextricably linked to their practical needs. This consultation has demonstrated that many of the young people I interviewed are without current and appropriate support for their mental health needs and this lack at this point in their young lives is very concerning.

- There were shared concerns about the mental health professionals being insufficiently trained to deal with distressing accounts of torture and sexual violence.

Diversity

- A number of stories of racism by health professionals were raised by members of the group. They wished labelling and racism to be better addressed at all operational and strategic levels within mental health services.

- There is a need for the promotion of a greater awareness of what mental health is amongst Asian communities, because although things may be slightly better than 10 years ago, there remains huge social stigma around mental health, and depression is often ignored within these communities and is dealt with informally within families The only difference of opinion related to the use of anti-depressants. Some people felt they helped, other people felt they had no effect.

- It was felt that long-term change could only be achieved by having a greater diversity at senior levels and all staff receive training that includes first-hand experience of interacting with refugees.

Listening

- Firstly it was felt that GPs displayed a lack of response to a patient when explaining their concerns and symptoms, which are very personal and require courage to talk to their GP. This provided an insight into the use of A&E and 'walk-in centres' rather than GP services, as the former offer longer consultations and it was felt listened to the patient more. Secondly, ward staff appeared uninterested as it was the 'same day, same evening' for them which again was interpreted as a lack of concern by staff for patients.

- Promotion and support for independent User Groups of user-involvement for shaping services, empowering involvement with a focus on improved representation of diverse communities and women at meetings and in decision-making processes

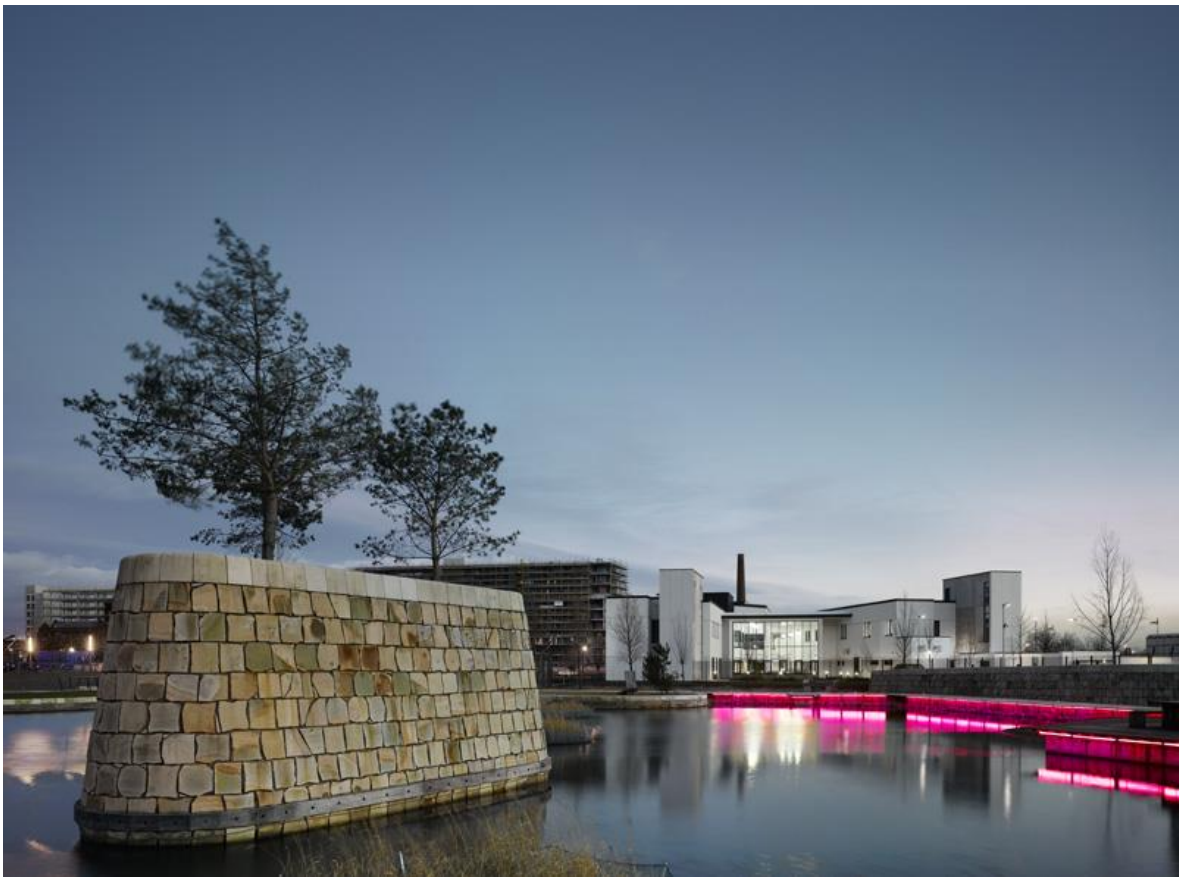
Social isolation

Social activities which addressed social isolation were really important.

Carers

- The most common view was that carers were not valued within the specification and that this mirrored the experiences they faced when interacting with professionals across NHS services. They overwhelmingly felt that they were collectively saving the NHS a great deal of money but that this was not recognised.

- Two participants were mother and son, both having severe and enduring mental health conditions. It was evident that this overlapping relationship of carer and 'patient' caused anxiety and contributing to their condition. This area of mental health caring by 'patients' needs further exploration investigating it both as a source of peer-support and ensuring appropriate support services are available.



A Charter for mental health services in Manchester

Following discussions about the existence within the voluntary and community sector of survey responses, results and reports from engagement events over the years, a draft charter for mental health services in Manchester has been developed by an advisory group.

The analysis was carried out by a steering group co-ordinated by Macc with members drawn from:

- Macc
- Former Mental Health Watchdog (Link), Patient and Public Involvement Forum and Community Health Council members
- Manchester Users Network and South Manchester Users Group
- Manchester Mental Health and Social Care Trust

The charter will have two main purposes:

1. To show commissioners and providers what service users would like the mental health services to do for them (what outcomes matter most to service users); this is particularly important now when commissioners are thinking about what outcomes they are going to seek from services
2. To express the perspective of people who use mental health services in a statement which they can develop and build on as they wish in their own discussions

The Charter for mental health services in Manchester is still being developed and further engagement on this is planned to take place in the summer.

Here are the Charter key headings:

- **We want to feel that we've been listened to**
- **We want to have a real influence on services**
- **We want to be part of services**
- **We want to be part of our own care**
- **We want services to decrease stigma**
- **We want services to think properly about the consequences of changing what they provide**
- **We want services that work for people from all the different communities and cultures in Manchester**
- **We want services to understand us as whole people**
- **We want to know what services are available**
- **We want to know what's happening in services**

If you would like a more detailed version of the Charter and the opportunity to read it and let Macc know if something important is missing, please email john@macc.org.uk or telephone 0161 834 9823.

Macc support for independent mental health forum

The charter advisory group aims to support the setting up of an independent forum for people who use mental health services. The forum will aim to strengthen the voice of people who use mental health services throughout the process of re-commissioning mental services for Manchester.

HealthWatch Manchester events

The steering group agreed to engage HealthWatch Manchester to set up and run ten local awareness raising events. It was agreed that HealthWatch Manchester would use their own existing stall, staffed by volunteers and supported by resources (leaflets, banners and, originally, a 'mood card') to be provided by the Clinical Commissioning Groups via the Greater Manchester Commissioning Support Unit.

Initial discussions looked at using the ten events as engagement opportunities, but the depth and complexity of the proposals meant that briefing HealthWatch volunteers to undertake the survey would be impractical. Instead it was agreed that the events would focus on raising awareness of the process, with three events each in north, central and south Manchester one in the city centre.

HealthWatch Manchester supported three events at Harpurhey, Longsight and Gorton and in total, 60 members of the public were spoken to and information shared on the on-going engagement activities and survey.

Mental Health Improvement Programme Launch Event

A public launch event was held at Cross Street Chapel on 20 November 2013. The event was well attended by service users, carers and health and social care professionals.

Small group discussions took place and the following key themes and information was noted:

- Personalised and individual outcome measures are needed as each person will have different aspirations
- Understanding of the importance of small steps planning for crisis/down times and recognising these will happen
- Recognising the role of the key worker, carers and circles of support in agreeing outcome measures
- Capable organisations and capable practitioners
- Knowing when to stop measuring certain outcome measures
- Being able to focus on different measures at different times
- Need to use many different forms of communication
- Need to classify caring and volunteer work as equal importance to "paid" employment

Manchester Mental Health and Social Care Trust Service User and Carer Forum

Manchester Mental Health and Social Care Trust kindly let us engage with their Service User and Carers' at their forum event at the Mechanics Institute on 27 January 2014. This enabled us along with Manchester City Council colleagues to talk and listen to feedback on the proposed pathways and well-being consultation. The event was well attended.

People spoke very strongly about the need to be listened to, for staff to hear their stories from their perspective and to not just be assessing level of depression or illness.

The following feedback was given at the event:

Carers

- Carers and immediate family should be included in all the care. Support, education and involvement are required for this group
- Communication across services is integral and should include the carer
- Supporting carers is very important
- Positive – crisis team recognise the carer's voice. This should be implemented across the whole system.

Outcomes and measures

- The step care model should be used to measure services

Diversity

- To have a workforce that is representative of the population they serve, with consideration given to the BME communities. The worker would then immediately start off with a greater understanding of someone's position and problems
- The importance for good and effective interpreters
- Language barriers increase isolation and ill health. Different languages need to be taken into consideration
- The South Asian women's group is closing. This will leave many women with no support and increase isolation

GPs

- If GP's knew of more interventions to help they would be less prone to just prescribe
- GP's often don't understand mental health and are dismissive of people's problems. If they understood more or had longer time they would make people feel heard and not just brushed off with some self-help leaflets
- GPs need to be trained and focus needs to be placed in primary care
- GPs are turning people away and asking patients to make a longer appointment. Help is needed then and there and the primary care system needs to support this
- Long term conditions – services need to talk to each other across Trusts

Acute Hospital Trusts

- Doctors at Accident and Emergency to deal with mental health

Prescribing

- If people are prescribed tablets they should also receive help with medication management and not just be left on drugs that they are experiencing side effects from

Caring and Compassionate services

- Receiving compassionate care is more important than outcome measures such as PHQ9
- People need warm and accepting communities
- Staff need to be more caring
- Currently patients feel that they are being looked down on and this attitude needs to change
- Currently staff morale is low which impacts on the service provided
- People reflected on the importance of good staff morale and how this impacts on the compassion they show to people who use services
- For non-mental health staff to understand mental health issues so as to not judge and treat people unkindly. Mental health services have a responsibility to promote understanding of mental health to other members of the NHS workforce

Communication

- Services need to communicate with each other so people don't have to repeat their stories. If a person needs help from many different workers, they need it to be tied together. For example, if a person needs to see someone for debt support, the mental health workers need to set it up for them, make it easy. These services need to be linked in and the same goes for substance misuse support
- The transition age needs to be communicated
- Need clear communication between organisations

Social Isolation

- There was a very large consensus of the importance of preventing social isolation
- Social isolation is often a natural by-product of experiencing a mental health problem, and perpetuates the problems. So measuring social isolation and enabling more inclusion is paramount
- Don't be reliant on IT systems in mental health, they promote social isolation
- Peer and community support is key

Feedback on the non-psychotic illness pathways

- Physical health care staff need to work with mental health staff in secondary care
- Therapy is needed in hospital not just medication. Link workers suggested to support up skilling of staff, for example an expert in depression, Obsessive Compulsive Disorder etc.

Community services

- Services are required which get people out of their homes to support with recovery as current pathways don’t place an emphasis on this
- Services should be available 24 hours a day, 7 days a week
- Support should be provided to help you stay in your own home
- Equal availability is required – high waiting times for those with more severe health
- More community services are needed to support recovery. Services run by service users are integral to recovery and will benefit all

Clinical Engagement Events

Eight clinical engagement events were held over four weeks during January 2014, on a full day basis. In total, 120 clinicians attended and participated in these events, which were facilitated by the Head of the Mental Health Improvement Programme and the Programme Lead for the Mental Health Improvement Programme.

The following GPs: Dr Shaun Jackson (North Manchester CCG GP) Dr Mike Capek and Dr Toby Cartwright (South Manchester CCG GPs), Dr Ruth Thompson and Dr Claire Sproson (central CCG GPs) also held four three hour meetings to scrutinise each pathway in comparison to patient vignettes of cases they work with. It provided a robust review process and generated lots of practical queries.

Clinicians and healthcare staff from the following organisations took part in the engagement events:

- Manchester Mental Health and Social Care Trust
- South Manchester Clinical Commissioning Group
- Central Manchester Clinical Commissioning Group
- North Manchester Clinical Commissioning Group
- Greater Manchester Police
- Self Help Services
- Greater Manchester West Mental Health NHS Foundation Trust
- Public Health Manchester
- NHS England Lancashire, Greater Manchester and South Cumbria Strategic Clinical Network
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Turning Point
- Gaddum Centre
- Richmond Fellowship
- Manchester City Council
- Alternative Future Group
- Emerge
- Select Support Partnership
- The Priory Group
- Care UK
- Age Concern
- Later Life Care
- Manchester Learning Disability Partnership
- The University of Manchester
- Calderstones NHS Trust
- Central Manchester NHS Foundation Trust
- Greater Manchester Probation Services
- Praxis Care
- Creative Living Centre

Table discussions were led by commissioners from the City-Wide Commissioning team, Quality and Safeguarding Team and Manchester City Council.

4 questions were asked at each of the clinical engagement events:

1. The proposed mental health care pathway service specifications show the services that will be available to people with different mental health problems. Are they the right pathways or do some need to be separated or merged? Is there anything we have missed?
2. We want to measure how well services are doing based on 'outcome measures' (what they achieve for patients) as well as on 'activity' (the number of appointments to see someone, or days in hospital they provide). Do the specifications ask for the right outcomes? Are we measuring the right things? Is there anything that you would do differently?
3. We know that good mental health care often needs different organisations to work together well. We want services to work together so that everything is well co-ordinated. What are the critical things that services need to do to make this possible? Is there anything that services should not do?
4. We may use 'outcome measures' to set financial rewards or penalties for service providers. Which outcomes are most important to you?

Feedback from these events has been included, where appropriate in the draft versions of the care pathways.

Here are some examples of the clinical feedback received:

- GPs play an essential role – Gateway service is not mentioned and GP's need to know what is happening. If GP's are not linked in, people are not going to get a good service.

- General consensus – would not want to see more pathways.

- It is very rare someone will present with just anxiety, it is usually complicated by another mental health problem.

- Specification requires an ethnic variation – it is difficult for those whose first language is not English to access the service.

- Substance misuse under psychotic pathways needs to be picked up in every care pathway.

- Outcomes – not just about diagnosis, but complexity, vulnerability and health inequalities.

- Rehabilitation could be community based as well as residential. This needs clarifying in the specification.

- Social and community engagement should be used as part do measuring social outcomes
- How are providers going to manage movement between different steps? Integration behaviour are key to this
- Risk of diagnostic care pathways, rather than patient need
- Move away from diagnostic care pathway and more towards step based care pathway
- Early diagnosis of Dementia needs to be timely and more explicit in the Pathway and outcomes linked to GPs
- Expertise needed around interpreting key to affective assessment. Translators having a knowledge of Dementia
- Understanding the Dementia population – particularly lower numbers of Asian residents accessing and being assessed despite the co-morbidities around diabetes
- For many the co-morbidity pathways can be confusing. It is important to distinguish between Psychiatric & psychological treatment.
- Ensure doors aren't shut to service because a person is homeless or not in crisis.
- Number of people don't fit into criteria for 'Eating Disorders' not specified. i.e. Anorexia traits – many who are psychologically troubled i.e. Anxiety/bereavement which can lead to eating disorders.
- Robust link between communities for someone with Personality Disorder. Inpatient should offer therapy management or relapse.
- Outcomes should be about social networks and engagement and helping people maintain these, it is often the best judge of how stable somebody is.
- Joint meeting with all providers and GPs to keep informed of good working standards for people with personality disorder.
- Green light toolkit should be used for all care pathways. 50% of girls in Emerge present with self-harm. One stop shop in one place so you can access services.
- Services for those with Autism/ADHD mild need to be specialist as well as having generic care pathways for all that are accessible
- A provider model to have strong connections with the third sector providers, schools, police and other agencies. Service should not operate in isolation (this could be an outcome).
- The social outcomes are very important. Looking at alternatives for people with Autism so they can work at their own pace.

Patient and Public Event

A final public engagement event was held at the Kings Conference Centre on 4th February 2014. Although there had been a low number of people in attendance, it provided the opportunity for service users and carers to have face to face discussions with the Mental Health Programme team and commissioners.

Printed A3 versions of the pathways were on display for people to read and talk through, as well as showing the Community Reporter videos outlined on page 31.

The following information was shared with us by service users and carers:

Autism Spectrum Disorder

- Staff needs to understand the world from the perspective of the service user and realise that people with Autism Spectrum Disorder can struggle with making day to day decisions; especially where there are multiple choices and options
- This can be very stressful for the person with Autism Spectrum Disorder, and it is important to work with the person's strengths and to work at a pace which suits them and not the clinician or professional carer
- Staff competences and experience of working with this service user group is key to the person's mental health and wellbeing. There needs to be an educational component in the care pathway for educational establishments and for employer's; to enable them to make the reasonable adjustments the person is entitled to
- Having a correct diagnosis is also key to the person being able to access these reasonable adjustments

Dementia and Carers

- Positive feedback was given about the Admiral Nurse Service; but felt it was over-stretched and needs further funding
- The Dementia café provides cares with an opportunity to have a break and to receive peer support and information
- Courses held at Park House re dementia are very good and help carers to understand the physiology of dementia
- Receiving the correct diagnosis is vital; one carer gave an example of a GP who minimised his mother's symptoms and said 'Its only old age', but the carer persisted until he got the correct diagnosis for his mother
- The importance of GP competence to be able to diagnose the condition and to recognise early signs and symptoms of it is vital to the care pathway working
- Carers need to have their own needs met and should be a valued member of the care team, instead of being treated as a 'nuisance'
- There needs to be more information about mental health and dementia in GP Practices, to raise awareness and to ensure it is on par with physical health problems

- The role of carers and the savings to public services which carers make by looking after the person with dementia should be more widely recognised
- Respite care is hard to obtain and increasingly so; and this links to the economic benefits of supporting carers to enable the person with dementia to live at home and as independently as possible as opposed to going into care
- Some carers give up paid employment to undertake their caring role and this can have a significant impact on the carer's family and their health and wellbeing
- Carers therefore need assistance to access benefits and the support they are entitled to through having their own needs assessed.

Child and Adolescent Mental Health Services (CAMHS)

- 16 and 17 year olds should stay in this service
- Lots of young people are very vulnerable and might not be ready for the adult world. Some might be savy but lots will not be
- Look at research from Leeds in 2013. Young people said they struggled with transition
- Onset of mental health could happen for 16 and 17 year olds, family needs to be supported to come to terms with this. Current model is a good model
- Integrated care pathways threshold can be tricky to navigate
- Not have a set cut off point but a gradual move towards adult services, shared care between Child and Adolescent Mental Health Services (CAMHS) and adult services

Communication

- The way in which care pathways are written need to be in lay language and not 'full of jargon and acronyms'
- Communication between inpatient, staff and the benefit system is very poor

Listening to service users

- User groups need to be independent
- Voices and not part of the 'lead provider'

Service Users and benefits

- Concerns that people who are discharged from services, go to ATOS who take their disability benefit from them. The person then gets ill again and relapses. ATOS staff have no mental health expertise
- How do people get helped to maintain their personal affairs? For support on finance, household bills or personal hygiene
- Activities being called voluntary work is problematic for benefits, because when benefits are reviewed it means a person is then classed as "able to work" – need to use the term "therapeutic work"
- Need to link to welfare advice and advocacy services

GPs

- GP's no longer have time to talk to you about your problems
- No information at GP's surgeries about mental wellbeing

Inpatient Activities

- Activities on Bronte ward very positive
- Ward meetings take place but not always attended by ward manager or matron
- Men's group and women's group also positive

Respite

- Respite support for users and carers is limited

Rehabilitation

- Need a clear exit strategy, pushing for outcomes for individuals. Clusters can't dictate what user's outcomes should be

Food and health

- There is evidence that good nutrition affects mood and mental functioning. It is important to consider this alongside the care pathways and relates to the need to consider general health needs not just focus on mental health

Crisis

- Short term preventative pathways need to be considered further to prevent crisis becoming an acute admission
- Need better co-ordination of crisis services. Crisis centre should be in the community not in an acute hospital setting

Peer Support

- Independent peer support should not be controlled by a big NHS Trust
- Peer support is important in terms of promoting hope and aspiration

Estates

- Co-location of services independent sector services and NHS ones – joint use of space

Voluntary and Community Sector

- Fragmentation between statutory and voluntary sector

Employment

- Social co-operatives could help with employment

Whole System

- Mental health must focus on whole systems and whole lives

Community reporters’ videos

Macc engaged People’s Voice Media to train and support up to 8 community reporters in using video journalism equipment and techniques to gather patient and carer stories.

Four short films were produced and displayed at the closing public engagement event. Links to each of the films are below:

- www.youtube.com/watch?&v=iLR5FqA7msk - Henri's film
- www.youtube.com/watch?v=DErvdo0j-4c - Joan's film
- www.youtube.com/watch?v=aoVDNPDj0-I - James' film
- www.youtube.com/watch?v=7XJlfHCcvPI - Parvin's film

Feedback from participants

“Overall, I found the Community Reporter training and film development an extremely empowering process and hopefully a medium in the future to express my thoughts, experiences and ideals. This is an intense course of work, I would have liked a far longer and far more intense training course, apart from the digital knowledge, I felt we would have done with more reporting skills and techniques. I wish the group was bigger and far more diverse; it would have been good to exchange ideas and thoughts between us all.
This will enable an invaluable real-time diary that can encapsulate the challenges I face as well as the people I care for on a daily basis, it is also a reflective process for me. I would try to encourage myself to use this medium on a daily basis if I could, after 12 years of caring I would want to document my life and those around me. It is cathartic and that with in itself is good”

“Still fighting the fight, but with some great skills I learnt from you, I feel far more motivated, but as always it’s the time factor….”

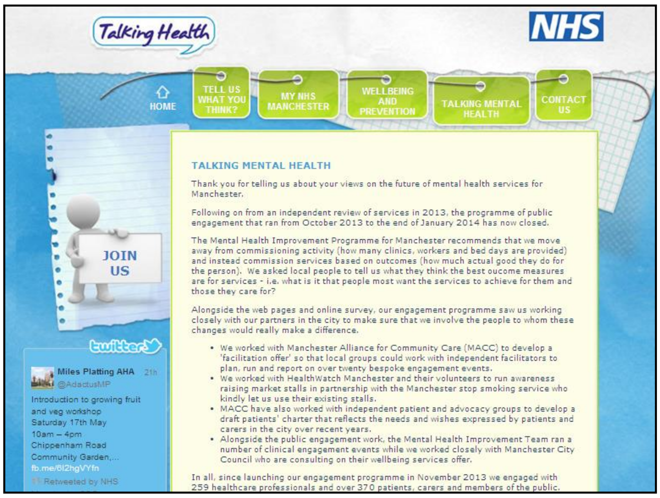
“I have problems with indecision and found myself being assertive, which is good.”

“I found it good as a therapy tool!”

http://communityreporter.net/feature/experiences-mental-health-issues

Use of digital and social media

Information on the 17 care pathways was made available on our Talking Health website under “Talking Mental Health”.



Miles Platting AHA 21h
@AdactusMP
Introduction to growing fruit and veg workshop Saturday 17th May 10am – 4pm Chippenham Road Community Garden,... fb.me/6I2hgVYfn
Retweeted by NHS

TALKING MENTAL HEALTH

Thank you for telling us about your views on the future of mental health services for Manchester.

Following on from an independent review of services in 2013, the programme of public engagement that ran from October 2013 to the end of January 2014 has now closed.

The Mental Health Improvement Programme for Manchester recommends that we move away from commissioning activity (how many clinics, workers and bed days are provided) and instead commission services based on outcomes (how much actual good they do for the person). We asked local people to tell us what they think the best oucome measures are for services - i.e. what is it that people most want the services to achieve for them and those they care for?

Alongside the web pages and online survey, our engagement programme saw us working closely with our partners in the city to make sure that we involve the people to whom these changes would really make a difference.

- We worked with Manchester Alliance for Community Care (MACC) to develop a 'facilitation offer' so that local groups could work with independent facilitators to plan, run and report on over twenty bespoke engagement events.
- We worked with HealthWatch Manchester and their volunteers to run awareness raising market stalls in partnership with the Manchester stop smoking service who kindly let us use their existing stalls.
- MACC have also worked with independent patient and advocacy groups to develop a draft patients' charter that reflects the needs and wishes expressed by patients and carers in the city over recent years.
- Alongside the public engagement work, the Mental Health Improvement Team ran a number of clinical engagement events while we worked closely with Manchester City Council who are consulting on their wellbeing services offer.

In all, since launching our engagement programme in November 2013 we engaged with 259 healthcare professionals and over 370 patients, carers and members of the public.

From the November to end of February 2014 Google analytics information tells us that:

- There were 1,186 sessions of people visiting the Talking Mental Health pages of our Talking Health website. *A session is the period of time a user is actively engaged on the website.*
- 57.84% of these sessions were first time visits to our Talking Mental Health pages
- 686 new users visited our Talking Health website
- 3,462 pages were viewed. *Please note repeated views of a single page are recorded.*
- People visited an average of 4.84 pages per session
- 4.45 minutes was the average session time people spent on the website

We also used our Twitter account (@ManchesterCCGs) to promote the engagement activity, provide links to the survey and pathways information to our 17,000 followers.

The hashtag #talkingmentalhealth was used and this enabled twitter followers and anyone who has an interest in mental health to follow the conversations we were having.

During November to February 2014, there was 267 tweets posted giving information on:

- engagement activities
- sharing links to the Talking Health website
- sharing discussions that were on-going at Clinical Commissioning Groups board meetings
- Re-tweeting tweets from community groups holding engagement sessions

There were 162 participants who engaged or shared the information and resources we were sending out.

There were 923,020 impressions, which mean that there were potentially this number of people who could have seen the information and links to resources were sending out.

Social media – what's all the fuss about?

- 77 per cent of 15 to 24 year-olds use social media
- 45 per cent of those aged over 16 years use social media at home
- half of all UK adults access the internet on a mobile phone[1]
- around 78 per cent of the population use the internet2
- in the UK, Facebook has 36 million users [3], Twitter 15 million[4] and LinkedIn over 13 million[5]
- YouTube is used by three-quarters of the UK's online population[6]

This information is taken from the Social Media Toolkit for the NHS from NHS Employers

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1 Ofcom (2013) *The communications market*.
2 OxIS (2013) *Cultures of the internet: the internet in Britain*.
3 Facebook, 2 Oct 2013.
4 The Telegraph (6 Sept 2013) *'Twitter claims 15m active users in the UK'*.
5 *LinkedIn Press Centre*.
6 Ofcom, op. cit.
7 OxIS, op. cit.

Analysis

A meeting was held with Senior Officers from the Clinical Commissioning Groups, Manchester City Council, Mental Health Improvement Programme Team and Mental Health Strategies to go through all comments received through the engagement process and decide systematically which comments should or should not be included, with a clear rationale for inclusion and exclusion.

Mental Health Strategies produced detailed analysis on all of the feedback from across the spectrum of engagement. These are reproduced below and are has feedback has been themed into proposals.

Mental Health Strategies analysis

The engagement process on the draft service specifications produced a very substantial number of responses: organisational responses from local provider organisations; solicited responses from voluntary groups; comments from individual local clinicians and other stakeholders; and responses via the online Survey Monkey system.

The table below outlines the methods in which engagement and feedback on the draft care pathway service specifications Version 4 and Version 6.4 (version 6.4 was available for the Public Engagement Day) was sought.

Mental Health Improvement Programme Communications and Engagement Plan (11.11.13 to 5.2.14)	Numbers
Patients / Service Users / Members of the public/Carers/Advocates	370
Staff / Healthcare professionals	239
Organisational comments from Foundation Trusts	3
Organisational comments from an NHS and Social Care Trust	1
Feedback from attendance at the MH Provider Engagement Group	12
Feedback from Manchester Learning Disability Partnership	4
Manchester City Councillors Meeting 29.1.14	10

Accepted changes to the care pathways:

	Proposal	Notes
1.1	There should be clearer acknowledgement that people's individual needs may draw on more than one specification; many patient's needs will range across the pathways	This principle was already in the specifications, but, given its relevance and significance, it has been given greater prominence and clarity. Providers will be asked to confirm how openness to more than one team will work, where relevant; and we will make clear that all care packages will have an element of liaison with other services
1.2	The need to collaborate with a broad range of public partners should be more clearly articulated	We have strengthened our references to this issue, and developed a more integrated approach to the procurement with Manchester City Council. We have also confirmed that integration behaviours will form part of performance monitoring, and added several additional specific measures to the integration behaviours
1.3	There should be a clearer "whole system" approach with Manchester City Council services, linking to Living Longer Living Better	This has been addressed, via the agreement of an integrated approach to procurement. The provider is encouraged to pay particular attention to the Living Longer Living Better model of neighbourhood based community teams, and to propose how its service models for delivery of this pathway will dovetail effectively with those models
1.4	More attention should be given to social support, both in the community and to inpatients, for example to sort out benefits or employment	In delivering this series of pathways, the provider will be required, across all of the pathways, to discharge Manchester City Council's statutory functions. These are specified separately, but should be read as an overarching requirement across all of the pathways
1.5	Personal goals and Patient Reported Outcome Measures (PROMs) should be included, as well as formal outcome instruments	We agree that it will be essential to agree and monitor personal goals, and we have clarified this, explaining that standardised care packages will need to inform individualised treatment plans. This is wholly compatible with also measuring standardised outcomes in such a way as to enable an understanding of the effectiveness of the overall service
1.6	The specifications should explain various aspects of the required approaches to care planning	We have added a separate and overarching care planning section addressing this issue. It contains material on: a. the care programme approach b. service user and carer experience c. cultural and community sensitivity d. carers' assessments e. safeguarding f. recovery, including links to generic health and wellbeing services g. navigation support / care co-ordination h. assessment i. shared care / prescribing j. crisis planning k. discharge planning l. physical health care responsibilities

1.7	The specifications should give an indication of the core expected elements of services to be provided	A simple list of “core expected components” was added to each specification, clarifying, in very broad terms, the type of services which providers are expected to provide in response
1.8	The outcomes framework should relate to the national mental health dashboard	We have made various amendments on this basis, including: • overall satisfaction with services among people with mental health related social care needs • the proportion of people with long-term mental health problems feeling supported to manage their condition • the excess under 75 mortality rate • reference to use of the Rethink integrated mental health / physical health pathway
1.9	Outcomes should include friendships and social activities	We have added this to the outcome framework
1.10	Outcome indicators should be culturally sensitive	We have added this to the outcome framework, noting that instruments should be culturally appropriate where possible
1.11	The service should be able to innovate / move beyond current National Institute for Health and Care Excellence (NICE) guidance	We have confirmed that this is accepted, provided equivalent outcomes are demonstrated and/or the innovation is being robustly evaluated
1.12	There is some concern about linking funding to outcomes	We are not currently proposing a rapid “wholesale” move to outcome-based contracting. We do however wish to measure and incentivise the achievement of positive improvements in the lives of patients. We have clarified our intended approach
1.13	Personality disorder is not a psychotic illness	We agree that this is not a psychotic illness, and this has been corrected in the final version.
1.14	Eye movement desensitisation and reprocessing (EMDR) should be available for Post-Traumatic Stress Disorder (PTSD)	This was already in the relevant specification, but the clarity of that has been improved
1.15	There should be a specific pathway for alcohol related brain damage and/or this should be referenced within the dementia pathway	Neurological services do not form part of these specifications. However, alcohol-related dementias will be managed within the dementia pathway, and have been mentioned there
1.16	All staff should be able to manage routine substance misuse alongside mental health problems. These should not be limited to opiates and crack. Screening for substance misuse problems should form part of routine assessments	This has been clarified in association with the requirement to develop protocols for working with specialist substance misuse services
1.17	Services’ responsibility for safeguarding should be included	This has been included as part of the overarching care planning specification
1.18	The main emphasis of any financial incentivisation should be on recovery	It has been made more explicit that recovery will be one of the potential focuses for development of Commissioning for Quality and Innovation (CQUINs) payments
1.19	Service users’ own perceptions of	This has been added to the sections seeking patient

	their safety should be measured	feedback
1.20	There should be different patient experience questionnaires for different services	This would be expected, and has been clarified.
1.21	Dialectical behaviour therapy should be available for women who significantly self-harm; transference focussed psychotherapy should be available for people with a personality disorder	These proposals are consistent with the available evidence, and the personality disorder pathway has been amended accordingly. We have also widened the general criteria to permit a less restrictive approach to the management of personality disorder
1.22	Within the Early Intervention in Psychosis pathway: contact need not last for as long as three years; all patients should have a crisis plan; "thought disorder" should be considered a psychotic symptom	These are useful clarifications from the current provider, and the relevant pathway has been amended accordingly
1.23	It should be explained that people with personal health budgets are opting out of this series of specifications, and that their services do not need to follow them	This is consistent with policy on this matter, and has been clarified in introductory material
1.24	Reduction in anti-psychotic prescribing for dementia should be a monitored outcome	This is consistent with national guidance, and the relevant pathway has been amended accordingly
1.25	More detail is needed on the proposed approach to transition from Child and Adolescent Mental Health Services (CAMHS)	More detail on the proposed approach has been included
1.26	The need for case/care management and navigation should be emphasised	This has been included in the overarching care planning specification
1.27	Services should demonstrate empathy and compassion	This has been included in the overarching care planning specification, including reference to the "6 C's"
1.28	Staff should be sensitive to cultural and community differences; interpreters should be used where required	This has been included in the overarching care planning specification
1.29	"Step 4" services should not be presumed to be inpatient services	This is not presumed, but has been further clarified
1.30	We should make clear that inpatient eating disorder services are not within the scope of these specifications	This is consistent with current national commissioning arrangements, and has been clarified
1.31	Other therapies are specifically approved by National Institute for Health and Care Excellence (NICE) for use in depression	We have added specific reference to depression counselling, short term psychodynamic therapy, interpersonal therapy, and couples counselling
1.32	Within the dementia pathway: medication can also be offered for Lewy-Body disease; there are	These are useful clarifications from the current provider, and the relevant pathway has been amended accordingly

	common interactions of dementia and depression; people do not need to remain on the specialist caseload until death; life story work should be undertaken; immediate delayed memory, recognition, and visio spatial ability should be assessed	
1.33	There should be a specific pathway for psychosexual services	We have added a separate psychosexual pathway
1.34	Condition specific tools should be referenced in autism	We have included reference to the Spectrum Star, and Model of Human Occupation Screening Tool
1.35	It should be clarified that GPs should have access for advice about patients they haven't referred, as well as patients known to specialist mental health services	This is consistent with common professional practice, and has been clarified as an integration behaviour
1.36	Do Not Attend (DNA) rates should be considered an indicator of engagement, and therefore a form of outcome indicator	This would clearly be a proxy rather than an actual outcome indicator, but we agree it is an indicator of engagement, and we have adopted it within our framework
1.37	The provider should be required to do physical health checks if the patient does not wish to engage with their GP	We have made provision for exceptional cases being handled in this way
1.38	Peer support should be explicitly encouraged	We have done so within the care planning framework
1.39	Home visits should be available for people mentally or physically unable to attend clinics	We have encouraged this within the care planning framework
1.40	Smoking and obesity should be monitored as outcome measures	We have added these to the framework
1.41	Within the eating disorder pathway a. the proposed specific typical weight gain targets should be deleted b. the requirement for a specialist diagnostic assessment should be added and clarified	This has been amended.
1.42	The "psychotic crisis" pathway should be renamed as "acute crises". Within this pathway it should also be clarified that a. crisis services must be willing to see people in Manchester who are homeless; b. if services see people temporarily in Manchester who are known to services elsewhere, those existing services should be notified as soon as possible	This has been amended.

	c. the four hour access standard should apply to home treatment as well as to inpatient admission	
1.43	There should be organised routes for service user voice	We have added reference to this issue in the overarching care planning specification
1.44	Services should decrease stigma	We have asked the provider to monitor patients' perceptions of this issue, so that overall progress can be monitored

Changes not accepted to the care pathways:

	Proposal	**Notes**
2.1	The overall structure should not be based on diagnoses. Proposed alternative structures include the care cluster structure, or unspecified arrangements based on complexity, risk and needs. Time should be allowed for a diagnosis to emerge	Diagnosis is mental healthcare is continually evolving, and is widely accepted to be an imperfect science. However, good healthcare relies on successful diagnosis of what is actually wrong with a patient, national guidance and research is substantially diagnostically based, and we cannot realistically develop a more evidence-based approach to care and treatment as well in any other way. The national care cluster structure is proving at least as controversial, if not more so, than a diagnostic approach. The pathways do allow for differing levels of complexity, such as via stepped care models, or permission of differing approaches to treatment. The only realistic alternative to the diagnostic approach so far adopted would be to specify a structure of teams and services, but leave some flexibility for providers to propose team roles and interrelationships. This principle is already acknowledged.
2.2	More detail should be provided about exactly how many beds, staff, services should be provided.	The specifications are deliberately high level at present, so as to encourage flexible and creative responses from prospective providers. We envisage developing considerably more detail in conjunction with our preferred provider later in the procurement process.
2.3	Specific staffing levels should be specified	Providers will be asked to explain their plans for both of these factors, but we are not currently planning to specify them in advance
2.4	More acute beds should be specified	
2.5	Full flowcharts and pathways should be included	We agree that full pathways would include the detailed flow-charts etc which some respondents have requested. As indicated above, we envisage developing considerably more detail in conjunction with our preferred provider later in the procurement process.
2.6	There should be a separate pathway for complex patients	There are many types of and reasons for "complexity", and it is not clear how such a specification could usefully be devised and monitored
2.7	Service provision needs to integrate with Manchester University's	This is a matter for the University, not for this procurement process

	research programmes	
2.8	FACS criteria and diagnostic criteria are sometimes inconsistent	These are differing processes, and we agree that some people will meet the criteria for one but not the other, as the balance of needs for health and social care will vary
2.9	There should be a specific pathway for bipolar disorders	These are already referenced numerous times in the specifications; we have also received comments about the current number of specifications, and we did not therefore decide to separate this into a different specification
2.10	There should be a specific pathway for phobias	This relates to (but is not quite the same as) the Obsessive Compulsive Disorder (OCD) pathway. We have also received comments about the current number of specifications, and we did not therefore decide to separate this into a different specification
2.11	There should be a specific pathway for mood disorders post stroke	We would look to our provider to develop protocols with acute providers on the management of these conditions. Following assessment, the patient should then be managed via the relevant specific pathway. There would be major resource implications of inclusion of such services at any significant level within this procurement process.
2.12	There should be a specific pathway for medically unexplained symptoms	
2.13	The neuropsychology service should be specified here / the FUNDD (functional neurological and dissociative disorder) service should be specified	We do not wish to distinguish this as a specific small service within the overall framework.
2.14	There should be a specific pathway for sleep disorders	We acknowledge the importance of such disorders, and that they frequently co-exist with mental health problems. We do not however regard these as a distinct pathway. Complex sleep disorders will not be the responsibility of the provider under this specification.
2.15	There should be a specific pathway for delirium	These are not mental disorders, and delirium therefore does not form part of these specifications
2.16	There should be a specific pathway for pre-clinical symptoms of anorexia	These services will be provided within primary care, rather than via a specialist provider.
2.17	There should be a specific pathway for dual diagnosis / mild to moderate mental health problems with substance misuse	There is already a pathway for mental illness and substance misuse; there are also requirements for protocols to be developed between all pathways and specialist substance misuse services.
2.18	There should be a specific pathway for self-harm in A&E	Our pathways are deliberately not setting-specific. People presenting with self-harm should be assessed and managed via the relevant pathway after assessment. We would expect the provider to develop detailed operational protocols with A&E services, but we wish to permit flexibility for providers to address the detail of this
2.19	There should be a specific pathway for survivors of domestic abuse	We have not created a separate pathway for survivors of domestic abuse on the understanding that the principles of care will not differ fundamentally from those set out in other pathways.
2.20	There should be a specific pathway for the needs of Lesbian, Gay, Bisexual and Transgender (LGBT)	Providers will be required to monitor access to services according to sexual orientation.

	people	
2.21	Anxiety is more complex than the current pathway allows for – for example health anxiety, and social anxiety	We agree that the treatment of forms of anxiety is more complex in its detail than the summary in the specification. We do not however wish to constrain the provider at that level of detail, and we are confident that the provider's professional staff will work appropriately with this complexity.
2.22	There should be a specific pathway for complex and traumatic bereavement	We have not created a separate pathway here on the understanding that the principles of care will not differ fundamentally from those set out in other pathways.
2.23	There should be a specific pathway for dementia services for younger people	These will be managed within the dementia pathway; we have deliberately not specified a lower age limit for these services.
2.24	The proposed waiting times and timescales could prove very challenging – will the resources be available?	We envisage this forming part of negotiations with the preferred providers; and potentially a need for some level of prioritisation within the available resources.
2.25	Relapse should be considered an outcome indicator	Prevention of relapse is clearly an important consideration. Specific inclusion of relapse as an outcome indicator could however encourage the provider to retain people in services longer than is desirable, and we have therefore not included it here
2.26	Commissioning for Quality and Innovation (CQUIN) funding could be retained to support innovation and service development	This could clearly be done, but it is a matter for contract negotiation, rather than specification
2.27	Post Traumatic Stress Disorder (PTSD) and panic should be in separate pathways	We agree that these are not the same, but we have also received comments about the current number of specifications, and we did not therefore decide to separate this into a different specification
2.28	Autism and Attention deficit hyperactivity disorder (ADHD) should be in separate pathways	We agree that these are not the same, but we have also received comments about the current number of specifications, and we did not therefore decide to separate this into a different specification
2.29	The specifications should make clear which services should be available 7 days a week, and out-of-hours	This is a good point, and the eventual contract needs to be clear about it. We will however seek proposals from bidders in the first instance, and handle this via contract negotiation.
2.30	"Serious" and "significant" risk should be defined more clearly	Such definitions would relate to risks of harm to the patient's health or safety or that of other people – but we expect providers to use their professional judgement rather than rely on (inevitably) general definitions for such matters
2.31	Concern whether there will be sufficient resources to provide Magnetic resonance imaging (MRI) scans to support dementia diagnoses	This is a matter for the acute contract, rather than for these specifications
2.32	Providers should be required to develop shared information systems, either within their organisation /	These things do clearly form potential indicators of a well-integrated service. Given their complexity and potential resource implications, it may be however difficult formally

	consortium, or with other partners, including shared Care Programme Approach (CPA) systems	to specify them as absolute requirements. It will clearly be necessary to discuss these issues with our provider over coming years.
2.33	There should be joint budgets, teams, co-location, training	
2.34	There should be a common email directory	
2.35	Better information should be available about services	
2.36	Staff satisfaction should also be considered an outcome measure	This will of course be an important issue for our provider to monitor, and we entirely accept its potential impact on service quality; this will be monitored, but not as part of these service specifications
2.37	Employment should not be stressed so strongly as an outcome indicator	This is a key indicator in all current national frameworks
2.38	"Patient Knows Best" could be used to support sharing of records	This is too specific a suggestion for inclusion
2.39	Outcomes should include access to physical health services / physical health should have equal prominence	This would be a difficult issue for which to hold the mental health provider to account in quite this way – although physical health outcomes are included within the provider's outcome framework
2.40	There should be different approaches for asylum seekers	Whilst this is of course true, it would be very difficult to specify all the relevant detail within an overall framework of this nature
2.41	Liaison with colleagues should be recorded as activity	Not really a relevant issue for service specification
2.42	Suicide should not be used as an outcome	Whilst the limitations of this indicator are accepted, it forms a core part of monitoring of outcomes of all mental health services at a national level
2.43	Contracts should be for 5 years	Not relevant for the specifications
2.44	There should be a common / single assessment	This isn't really feasible across the range of pathways, and needs within them; we have however noted that the provider should minimise the need for patients to repeat their "story" multiple times as part of the assessment process
2.45	There should be less emphasis on psychometric testing	Such tests form a key element of assessment, as well as measuring progress and outcomes
2.46	Psychiatric and psychological treatment should be clearly distinguished	We are not specifying the roles of particular professions, and we are seeking an integrated and multi-disciplinary approach
2.47	Vulnerability is more relevant than mortality in dementia	It is not clear how this would be measured
2.48	More emphasis is needed throughout on early intervention	This is referenced numerous times within the framework already
2.49	Clinical leadership is key	Agreed, but more of an evaluation issue than a specification issue
2.50	All raw data about services should be publicly available	This wouldn't be feasible or legal as phrased. Information shared with commissioners in aggregate can be placed in the public domain, in accordance with relevant guidance
2.51	Concerns whether GPs will be able /	May or may not be founded in some cases, but not an issue

	willing to pick up the responsibilities it is indicated they will have	for these specifications
2.52	Insufficient attention is being paid to the effects of childhood trauma	We do not describe any of the many potential causes or triggers of mental health problems. We would expect such factors to be considered routinely as part of professional assessment.
2.53	Rehabilitation and recovery services should be addressed separately	It is not clear what is being asked for here, as these are very closely related concepts
2.54	Specialist eating disorder services should deal only with people in clusters 5-7, not 1-4	The current specification would permit referral of people in clusters 1-4; the cluster criteria make clear that people in these clusters may have an eating disorder
2.55	Particular attention should be paid to the needs of students	We are not currently describing the particular needs of any group within the Manchester community, other than according to their mental health problem
2.56	There is concern that the process could result in the transfer of some NHS directly provided services to private sector providers	Any procurement process will need to comply with the relevant law
2.57	There should be specific outcome measures for later life	Our approach has been deliberately to seek an ageless service
2.58	There should be separate pathways for later life	
2.59	Health and social outcomes should not be separated	These are simply divisions for ease of understanding within potentially long lists of outcomes. No hierarchy of importance is suggested.

Outcomes of Macc engagement events

An overall analysis of changes arising from the overall engagement process was prepared on 13th February 2014. This included consideration of themes and issues raised by the Macc engagement events, as part of the wider series of events and processes between November 2013 and February 2014 to gain comments on the draft mental health pathways.

The information below considers only the Macc events, and has been prepared following a further specific review of only the material generated by those events. The table does not provide a point-by-point answer to every point raised in the MACC events; it instead analyses the main points and issues commonly raised, as well as salient individual points, and presents responses. These are divided into three categories:

1. Requested changes which it has already been agreed to accept, and for which the specifications have therefore already been amended.
2. Requested changes which it has already been agreed not to accept, and for which the specifications have therefore not been amended.
3. Requested changes which have not so far been specifically discussed by the Clinical Commissioning Groups and Manchester City Council.

1. Changes accepted

	Proposal	**Notes**
1.1	There should be clearer acknowledgement that people's individual needs may draw on more than one specification; many patient's needs will range across the pathways	This principle was already in the specifications, but, given its relevance and significance, has been given greater prominence and clarity. Providers will be asked to confirm how openness to more than one team will work, where relevant; and we will make clear that all care packages will have an element of liaison with other services
1.2	More emphasis should be placed on the roles of carers, family and friends	This has been developed further within the care planning section
1.3	Prevention / health and wellbeing are as important as treatment services	Specifications for these services have been developed separately; the requirement to maintain good links with those services has been written into all of the pathway specifications
1.4	The specifications should reflect individuals' personal goals, not simply standardised measures. There should be respect and dignity for the patient as a person, and the patient should have a say, and a choice.	We agree that it will be essential to agree and monitor personal goals, and we have clarified this, explaining that standardised care packages will need to inform individualised treatment plans. This is wholly compatible with also measuring standardised outcomes in such a way as to enable an understanding of the effectiveness of the overall service.
1.5	Having a named care coordinator / designated care worker is really important.	We have added a separate and overarching care planning section addressing this issue. It contains

	The need for case/care management and navigation should be emphasised	material on: m. the care programme approach n. service user and carer experience o. cultural and community sensitivity p. carers' assessments q. safeguarding r. recovery, including links to generic health and wellbeing services s. navigation support / care co-ordination t. assessment u. shared care / prescribing v. crisis planning w. discharge planning x. physical health care responsibilities
1.6	Outcomes should include friendships, social activities, and reducing social isolation	We have added reference to these issues to the outcome framework
1.7	Outcome indicators should be culturally sensitive	We have added this to the outcome framework, noting that instruments should be culturally appropriate where possible
1.8	There should be more recognition of dual diagnosis (substance misuse) within common mental health problems	We have added requirements for all services to be in a position to manage substance misuse problems as part of routine care.
1.9	Services should demonstrate empathy and compassion	This has been included in the overarching care planning specification, including reference to the "6 C's"
1.10	Staff should be sensitive to cultural and community differences; cultural and religious needs should be considered	This has been included in the overarching care planning specification
1.11	Peer support should be explicitly encouraged	We have done so within the care planning framework
1.12	There should be better communications between GPs and consultants	We have explained the key requirements within the integration behaviours section
1.13	There should be organised routes for service user voice	We have added reference to this issue in the overarching care planning specification
1.14	Services should decrease stigma	We have asked the provider to monitor patients' perceptions of this issue, so that overall progress can be monitored

2. Changes not accepted

	Proposal	**Notes**
2.1	The overall structure should not be based on diagnoses. The pathways are too prescriptive, difficult to relate to everyday life, not appropriate for people leading "complex lives."	Diagnosis is mental healthcare is continually evolving, and is widely accepted to be an imperfect science. However, good healthcare relies on successful diagnosis of what is actually wrong with a patient, national guidance and research is substantially diagnostically based, and we cannot realistically develop a more evidence-

		based approach to care and treatment as well in any other way. We understand that these documents are therefore written in "professional" language, as they are intended to guide the establishment of such properly evidence-based services. The only realistic alternative to the diagnostic approach so far adopted would be to specify a structure of teams and services, but leave some flexibility for providers to propose team roles and interrelationships. This would move us away from the outcome-focus which we are explicitly seeking.
2.2	There is a concern to enable easy access to psychotherapies even more quickly than set out in the specifications	The existing targets will prove very challenging, we expect. We envisage this issue forming part of negotiations with the preferred providers; and potentially a need for some level of prioritisation within the available resources.
2.3	Insufficient attention is paid to sexual trauma	We do not describe any of the many potential causes or triggers of mental health problems. We would expect such factors to be considered routinely as part of professional assessment.
2.4	There is insufficient attention to the links between physical and mental health	We have a specific pathway on this topic, and physical health outcomes are included within the outcome framework
2.5	There should be different approaches for asylum seekers, and partnerships with immigration services	Whilst this is of course true, it would be very difficult to specify all the relevant detail within an overall framework of this nature
2.6	More therapies should be available outside working hours	We will ask prospective providers to explain their approach to out-of-hours services in their bids, and consider this issue at that stage
2.7	Significant concerns whether GPs will be able / willing to pick up the responsibilities it is indicated they will have	May or may not be founded in some cases, but not an issue for these specifications
2.8	Concerns that GPs are not the most suitable gatekeeper for all mental health services	Self-referral will be permitted to some services; but the fundamental concern about the variable quality of local GPs is not an issue for these specifications.
2.9	There is concern that the process could result in the transfer of some NHS directly provided services to private sector providers	Any procurement process will need to comply with the relevant law

3. Points for further consideration

	Proposal	**Notes**
3.1	Outcomes for carers should be monitored as well; there should be a separate carers' pathway	We do not currently require outcomes for carers to be monitored separately via this contract, but this could be done if required

3.2	Outcomes should emphasise the ability to carry out activities of daily living	These factors form a large part of the outcome instruments which are already being recommended
3.3	There should be less competition between agencies	This approach is intended to reduce fragmentation between providers
3.4	More respite services should be available for carers of people with dementia	Such services are not currently within the scope of this contract
3.6	Concern about the side-effects of medication, and the need for medication awareness (what it is, and why it works)	We have repeatedly made reference to the requirement for medication to be prescribed only in accordance with NICE guidance, which should address this concern as far as is currently possible.
3.6	Faith-based treatments should be available	There is no mention of such treatments within the relevant national guidance. Although there is recognition of the value of spiritual support to some patients, this is perhaps something to be addressed by the relevant religious community, rather than via a statutory service. It should be noted that some MACC interviews clearly did not themselves welcome this idea.
3.7	Financial incentives should link directly to customer satisfaction	We have so far mentioned the application of incentives only in fairly general terms, planning to deal with this as part of contract negotiation.
3.8	Meditation can be important	This may well be true for some patients
3.9	There should be dedicated services for young people	We have so far maintained an ageless approach to adult services, but prospective providers may propose such arrangements within their bids
3.10	There should be more emphasis on family therapy	This is already referenced several times within the specifications
3.11	Advocacy services are very important	We agree, but we intend to continue to procure advocacy independently of the main provider
3.12	The pathways will drive resource allocation, and systematically result in reductions in care	This is absolutely not the intention of this process, which should ensure much better use of our existing resources
3.13	More information should be provided about services, including more use of audio and video in provision of information	We will look to our provider to ensure that this is attended to effectively
3.14	Concern that some people will need life-long treatment	The specifications acknowledge that this may be required in some cases
3.15	Constant changes of staff should be avoided	This is a matter for the future provider, not for the specifications
3.16	The care coordination service should be an independent body	We have no wish to commission this separately from the main provider, as we wish to maintain an integrated service arrangement
3.17	More support is needed for independent user groups	This is not a matter for these specifications
3.18	There should be more ethnic minority staff	This is a matter for the future provider, not for the specifications
3.19	Awareness-raising is required among deaf people	We have not distinguished the specific needs of specific communities in this way, as the number

		of needs and pathways would quickly become unmanageable. We would expect the appointed provider to work professionally to address such specific needs
3.20	There should be more support for people to plan their finances / get welfare advice	This will form part of the intended social care and health and wellbeing services
3.21	Work to address the social causes of mental ill-heath are needed more than psychotherapies	We do not regard these as mutually exclusive; both can and will receive attention
3.22	More services should be provided outside clinical settings	This is a matter for the future provider, not for the specifications. We will look to evaluate this issue in prospective bids
3.23	One provider will be too far away from frontline services	We consider that the need to reduce service fragmentation is very important; the provider will of course need to maintain effective communications with its various frontline services

Manchester City Council Mental Health and Well-being Consultation

On the 1st April 2013 Public Health budgets and contracts transferred to Manchester City Council. These included contracts for the provision of a range of healthy lifestyles services and healthy living networks. A decision was made to review and redesign these services for the following reasons:

- To ensure that they are delivering the services that will be needed from 2014 onwards
- To ensure that they are operating as a coherent system in the context of the new health and care system
- To ensure that they are providing the best possible public health return on investment.

In May 2013 Public Health Manchester within Manchester City Council set out the initial high level options for review of lifestyle services in a paper that sought to get views on a number of key questions about these options, in order to guide future planning.

This options paper was distributed widely and this review process included widespread informal discussions with commissioning partners, providers and the community and voluntary sector during summer and autumn 2013. A summary report of this review can be obtained from Sonia Andrade at **s.andrade@manchester.gov.uk**.

Views were also sought in the formal Mental Health and Wellbeing consultation programme undertaken by Manchester City Council between November 2013 and February 2014. Wide ranging views and responses have been received to this consultation and the design of a new Health and Wellbeing model is now nearing completion.

The following information summarises the Mental Health and Wellbeing consultation programme undertaken by the City Councils Commissioning Team between November 2013 and February 2014.

A full consultation report will be available from Michael Salmon, Commissioning Manager by email at **m.salmon@manchester.gov.uk** or by telephone on 0161 234 4557.

Mental Health and wellbeing services in Manchester are currently provided through a partnership between Manchester City Council and the Clinical Commissioning Groups. Both are looking at how these services are delivered in the city and how the system can be improved. An important role for the Council is to support people that have suffered from mental ill-health and fund specialist mental health services to do this.

The Manchester City Council consultation consisted of:

- An online questionnaire
- Access to information and a survey via Manchester City Council website and the Talking Health website
- 3 drop in sessions
- 2 stakeholder workshop design sessions

- Peer Support Development Session – Facilitated by Macc
- Commissioner visits to providers and 4 service user groups

Over 470 people were consulted and provided responses covering a range of stakeholders – members of the public, service users, carers, professionals, providers and organisational feedback. 333 responses were received from the online questionnaire, with the remaining number made up through the activities highlighted above.

Throughout the consultation process information on the whole system has been captured and shared between colleagues reflecting the integrated approach to this work and to influence the development and changes to the proposed model and specifications.

Key themes from the feedback included:

- In relation to supporting people with mental health and other health related problems to achieve their to personal goals and aspirations, 41% of respondents felt that **volunteering** is very important
- In relation to supporting people with mental health and other health related problems achieve their to personal goals, aspirations, 54% of respondents thought it was very important for the Council to support people with mental health and other health related problems around **employment**
- 58% of respondents agreed **investment** should be prioritised to prevent people becoming unwell

The online questionnaire provided respondents with the opportunity to add further comments through 'free-text'. The analysis of the free-text responses highlighted 5 areas mostly commented on by those that responded:

1. Retain high end funding
2. Consultation issues
3. Look at inclusion, isolation, peer support and whole family commissioning
4. Reduce delays and waiting
5. Commission hobbies, art and culture
   Improve partnerships
   Better holistic assessment

Summary of feedback from drop in sessions , design workshops , visits to forums
The drop in sessions, design workshops and visits to forums consulted with members of the public, service users, carers, professionals and providers. The feedback from this is summarised below:

Whole Mental Health System

- Strong feelings from service users and carers that the whole system design needs to maintain a 'person centred' approach otherwise this will be a missed opportunity to actually make a 'real' whole system change.
- The integration development of the Health & Wellbeing Service is potentially seen as the only major difference that will result from all of this work.

- There is a lot of crossover of services which need to remain person centred, particularly as individuals have multiple conditions. There needs to be training for frontline staff around the links between physical and mental health.
- The need for more integration with Health & Wellbeing services is key particularly around the development of peer, one to one and community support which people feel could bridge the gap both in relation to the access, waiting times or specialist's services and step up and down from those services.
- Step up and step down interconnected to specialist and wellbeing services support. This all must depend on the individuals needs as they will have to step up and down from services at different stages of their journey.
- Need to tie in commissioning by Public Health England into these proposals and whole system design.
- Relationship between the City Council and CCGs is critical to the long-term success of any new delivery model. Population data and preventative approaches need to be integral to the provision of mental health services…embedding recovery approaches in secondary care and supporting psychological therapies and self-care in primary care.

Proposed Health & Wellbeing Model

Capacity

- The need for one to one community based lifestyle/navigation type roles has been a continuous theme - Capacity needs to be developed and can offer more around barriers, providing support for assessment and access/navigation to specialist services
- Need people with the right skills to actually get people engaged
- Service delivery needs to be prioritised and infrastructure and admin only a proportion – phone line, website

Support

- The development of Peer Support and community based services has repeatedly been commented on as an area for further development that will need to be resourced and should not be viewed as a 'cheaper option'
- Infrastructure for the network is key, particularly if you want to develop peer support, one to one and community based services
- Training element of network important for professionals and service users

Joined-up services

- People feel that it is an opportunity to use commissioning to jointly resource Health & Wellbeing Services, setting outcomes and performance measures that will bring mental health professionals closer to community based support e.g. Health & Wellbeing Services clustered around GP's in localities (still feeding into a bigger centrally managed system), with the one to one roles providing a wider range of support around debt management, work and skills, healthy lifestyles etc.

This could provide GP's with a more consistent first point of support/referral and alternative lifestyle options rather than prescribing anti-depressants.

Promotion

The new network needs to be publicised through a variety of channels and formats to ensure that it is accessible and inclusive

Realism

The proposed model is good in theory but aspirational and idealistic and now needs to be stripped down, with more detail developed

Voluntary Community Sector

- VCS groups locally based, community relationships and networks that could be utilised and developed further
- VCS groups often work in partnership because they have to but there is a gap between health professionals awareness of what VCS providers can offer
- Some VCS organisations have a number of services under one roof which is positive for the service user, particularly for minority groups and where there are barriers to individuals accessing other services. They can bridge the gap and provide peer support
- VCS groups are struggling to manage the demand in communities - existing groups and newly arriving communities
- Services on the ground need further investment in order to manage the demand – in some cases VCS are propping things up and unable to manage the demand

Peer Support Development Session Summary

The Peer Support Development session was facilitated by Macc, using the existing ‘Recovery Network’. This session involved 40 participants and focussed on enabling ‘Recovery Network’ members to:

- describe what a quality peer support services would look like
- comment on a proposed model for developing peer support networks and services
- discuss how we would know if it is working well and
- advise on how it could be monitored

Peer Support was viewed as a key area of development and further investment for the proposed Health and Wellbeing Service, and those taking part in the development session agreed with the principle of a core service being commissioned. This would support the development of a diverse range of peer support networks and services and strategic links with education and employment. Participants thought that the service should have both specialist mental health and generic elements.

Comments/Frequently Asked Questions (FAQ’s) and Feedback Responses

The consultation has generated a number of feedback comments and Frequently Asked Questions with some of the key points highlighted referring to the:

- Whole system person centred approach
- Health and Wellbeing Services providing holistic support to individuals
- The development of community based services, one to one and peer support as key area
- The need for sequenced interventions and stepped care between specialists and Health and Wellbeing Services
- Rationale for prioritising resource
- Consultation issues

The consultation feedback is directly influencing the development of the Health and Wellbeing Service model and specification and is continuing to feed into the integrated whole system approach between the City Council and CCG's clinical care pathways for mental health.

The new Health and Wellbeing specification is being developed to include:

- A core service with a telephone line and assessment triage function
- A range of one to one support including Peer Support, Health Trainers, Lifestyle Coaches, Specialist Mental Health Lifestyle Coaches
- A quality assured network of providers and links to a range of community based services
- Links to clinical pathways and access into Health and Wellbeing Services including physical health.

Lessons learned

A number of comments were received about the consultation process specifically with regards to needing a longer period for feeding back, accessibility issues for different groups, the consistency and format of information and documentation used throughout the process. Whilst the consultation was delivered over a 12 week period (advertised on the City Council website and through other communication sources) we acknowledge that an event was cancelled at short notice due to low numbers and that the scope of the consultation was broaden to include wider population based Health and Wellbeing service discussions. The feedback has been recorded and will be used to inform the design and delivery of future consultation sessions.

Summary and Recommendations

The consultation report highlights some of the concerns and complexities within the current mental health system and reinforces the challenge for commissioners in Manchester is to develop a mental health system which can deliver high quality, sustainable services in the long term. Running throughout this is the message around the need for a whole system approach that remains person centred and provides integrated and sequenced services as part of an individual's journey. Further to this, the consultation has presented the need to ensure that an evidence base is used to inform the way in which resources are balanced between high end specialists services, with a shift towards developing more early intervention and prevention as part of a longer term strategy.

The recommendations from this report are to:

- Progress with the development of the Health and Wellbeing Service specification detailing the functions of the core service, one to one, peer support roles.
- Follow up with the work with stakeholders on the development of peer support
- Further develop and specifically articulate the links between the Health and Wellbeing Service and clinical pathways
- Develop a forward plan for communications and reporting on the Health and Wellbeing Service and whole system approach, in partnership with the CCGs and with stakeholders.

Health and Wellbeing Consultation Comments/Frequently Asked Questions and Responses

	Comment / Questions	**Proposed response**
1	Confusion about the change to population Health and Wellbeing services from Mental Health - Good idea but not clearly focused and almost too high level and generic in parts	A review of the city's lifestyle and wellbeing services has been underway since the transfer of Public Health to the City Council. This review process has included widespread informal discussions with commissioning partners, providers and the community and voluntary sector during the summer and autumn 2013, and as part of the consultation programme on the proposed pathway to Health and Wellbeing from November 2013 to February 2014. Wide ranging views and responses have been received to this review process and are informing the design of the new model.
2	It is unclear whether it means 'Wellbeing' services should be for the whole population, with or without physical and/or mental health problems, or for people with an existing 'health condition' (mental or physical), or whether it is trying to address the wellbeing needs of people who have, or may develop, mental health problems.	Health and Wellbeing services are a critical part of the city's Public Health system. They exist to support people to improve both their physical and mental health and wellbeing through changing their behaviour, cognition, and/or socio economic circumstances. As well as being open to the general public, they are a core component of a number of more specialist health and social care pathways.
3	The model diagram suggests that you need to access specialist services to access Health and Wellbeing Services. This needs to be the other way round, Health and Wellbeing Services for everyone and links into specialist services/stepped care	This diagram used during the consultation has been updated to reflect access to the service for everyone and the links to and from specialist services as part of a stepped care approach.
4	Several attempts to complete the online questionnaire but found it difficult to rank the items which had not been clearly defined. It was also unclear	The consultation and questionnaire aimed to reflect the challenge of prioritising resources against need, developing more early intervention and prevention whilst focussing on recovery and increasing

	whether the rating was important to the individual of Manchester as a whole	independence for individuals across Manchester.
5	Model put forward not described fully enough to allow for formal consultation. We have therefore assumed this is an engagement process to canvass views and opinions on future service options	We wanted to share some of the initial ideas being proposed for the pathway to Health and Wellbeing (Service) to ensure that the views and opinions of service users, carers, professionals and organisations inform the development of a more detailed service specification.
6	How will feedback be presented to stakeholders and will there be further opportunity to be involved in the design of the system?	Feedback will be included in a joint report on the engagement and consultation programmes delivered by the City Council and CCG's/Mental Health Improvement Programme. This will be made available via both websites and circulate across networks, with future opportunities to be involved advertised accordingly.
7	How can the results of the online survey, the workshops, and individual written responses like mine be compared – as they are not covering the same information?	The feedback and results from each aspect of the consultation have been collated and analysed and will present key findings and lessons learned.
8	Will we be bringing health, social care, VCS, service users together as a forum to develop these proposals and model?	There are no plans at present to develop new forums to discuss these proposals however we will continue utilise existing networks, forums and structures to develop the model with stakeholders.
9	How does the new whole system redesign differ from what we currently get with the stepped care model that doesn't work for us? (We need to have an understanding of the current model, to be able to see how the new model will work better)	An independent review of the mental health sector was commissioned, in late 2012, by the CCG's and the City Council to ascertain how well services in Manchester worked. The results of this highlighted that the current system is complicated, difficult to navigate access to services, with long waiting times, not enough focus on recovery, early intervention and prevention and outcomes. Given the level of funding (approximately £100million) that goes into this area, changes have been needed and this has led to the development of joint commissioning intentions between the City Council and CCG's to address this. Mental health is an essential element of the "Living longer, living better" strategy, in terms of our ambition to support communities to achieve high levels of mental wellbeing, and in terms of our responsibility to ensure that good mental health services are available for people experiencing episodes of mental illness.
10	A full mapping exercise needs to be carried out prior to any decisions being made in relation to moving funding from high cost mental health services. Next Step has already demonstrated the cost savings to the City and moving funding may not prove beneficial without it being	MCC's strategic commissioning intentions place recovery for citizens and recovery orientated practice for service providers at the heart of future mental health service delivery models and will see investment into early intervention and prevention whilst meeting statutory duties.

	tested first. An evaluation of savings using the Department Of Health (DOH) methodology would be useful.	The following highlights some of the key pieces of work already being carried out by mental health commissioners in the Council to help to inform our future decisions: • The tendering of mental health care homes under a new recovery orientated specification, outcomes monitoring and pricing framework. • The development of the new mental health home care contracts; this service is based on a new service specification that moves away from a traditional task driven care service to an enabling service focused on outcomes that reflect the recovery principals. • A strategic review of Mental Health Supported Housing. • The pilot of new Brokerage Team that will identify accommodation more efficiently and make greater use of the private rented sector. • A strategic review of all Mental Health Voluntary, Community and Faith Service (VCFS) provision to explore opportunities to make better use of VCS organisations to build peer support networks. • A review the interfaces between local authority and mental health services for children and young people. This will include links with the Looked after Children Strategy, the Troubled Families Programme and the Living Longer Living Better blueprint. • A review of the transition phase of mental health services age 14 to 18 • Continuation of work to better integrate mental health and employment and skills support services for those who are capable of work.
11	The document refers to preventing more people needing high-level / high cost services by improving wellbeing and preventing mental ill health...Where is the evidence that many of the people currently using such services can be 'cured' so that they will not need such services in the future?	We are not suggesting that improving wellbeing will 'cure' service users, our intentions are to support those individuals where appropriate with a focus on recovery, supporting the move towards independence and to move funding where possible to services that promote wellbeing for the whole population of Manchester. The City Council has and continues to review evidence about mental health interventions. This has highlighted the close links between a person's circumstances and their mental health, someone's physical health, housing, employment status, lifestyle choices and social networks will all have a factor in an individual's wellbeing. The extent that these

		circumstances will affect a person's mental health will depend on their resilience. Effective and sustainable services will not only be services that help to eradicate the issues that affect someone's mental wellbeing but also to give people the skills and resilience to maintain a level of good mental health despite their
12	How will need, particularly of marginalised groups, be considered in the overall design of services and commissioning?	The development of commissioned services will be informed by needs analysis, national and local research, intelligence and data and feedback from stakeholders, to ensure that services are prioritised on need and achieving outcomes. For example, strategies such as 'No health without mental health'(2012) identifies a number of groups who may be at higher risk of poor mental wellbeing or experience barriers in accessing support, including: • people from diverse black and minority ethnic communities • people with a learning disability • women • men in relation to higher suicide risk • the lesbian, gay and transgendered population • People with long term health conditions and disabilities • Those who have suffered abuse and/or domestic violence
13	Increased resilience – self-care could be more explicit	This has been noted and is being strengthened in the development of the proposed Health and Wellbeing service specification.
14	Evidence based interventions - Need to be clear about which evidence we have confidence in. Whose evidence?	This will be a combination of evidence based interventions that are known to the Council through existing and on-going research and intelligence, along with the opportunity for providers to demonstrate the evidence base and impact of interventions. The combination of this will be used to inform future commissioning decisions including where possible the financial/economic benefits
15	Accessible and inclusive suggested as a stronger principle (than clear and transparent)	This has been noted and is being consider for the proposed Health and Wellbeing service specification.
16	Principles – Building on strengths needs to include the strengths of current services as well as individuals and communities	We agree and this is a key aspect of our commissioning intentions and the proposed Health and Wellbeing Service
17	Principles – Outcome based services asked to be added	This has been noted and is being consider for the proposed Health and Wellbeing service specification.
18	…we are unclear as to what measurement tool is being used to assess what is working well...It would be useful to have an indication of the criteria being	The outcomes framework will form part of the detailed service specification. As a baseline we will look at existing services and which of those have evidence of achieving outcomes.

	used for monitoring which services work well, so that we can align our services with this measurement tool.	
19	Community Outcome needed for whole community - Building Healthy Communities?	The proposed Health and Wellbeing service will look at outcomes at both a citywide and local community level.
20	The six outcomes which are suggested will all be affected by many factors not just services which may be commissioned. It is not clear why the consultation asks for them to be ranked in order of importance and as they are all inter-related this is not possible to do	We want to measure the success of services that we commission against the outcomes that they achieve for citizens. Whilst recognising that the outcomes are interlinked, the consultation and questionnaire aimed to reflect the challenge of prioritising resources against need and developing more early intervention and prevention focussed on recovery and increasing independence for individuals across Manchester.
21	Is it intended to try to measure these outcomes for the whole population or for particular groups, or for users of specific services?	We will measure a combination of population based outcomes and outcomes for specific groups and services.
22	Will services be expected to meet all six outcomes, even if they are specialists in just one of them, for example, reducing debt?	The proposed Health and Wellbeing service will contribute to all six outcomes through its range of services/network links.
23	How will (outcome) baselines be assessed?	Outcome baselines and performance frameworks will be established and agreed as part of the Health and Wellbeing Service contract.
24	What research has been done across the country - other areas have developed similar Health and Wellbeing (lifestyle) services	We have looked at other areas that have developed or are developing similar Health and Wellbeing Services and taking learning from their experiences and service models
25	Can the model be developed so that referrals can be made from GP's to resourced peers and community support?	The proposed (core) Health and Wellbeing Service will provide **One to one services:** receiving referrals from a range of sources (including GPs and self-referral); conducting biopsychosocial assessments; providing appropriate one to one or group based motivational and psychosocial interventions, including life coaching; advocacy, peer support; and supporting people to access other services as appropriate. This part of the system will include "step down" support for mental health recovery The approach will include seeing people as "members" of the health and wellbeing service, bringing opportunities for on-going communication and engagement with members even after their use of more intensive services has reduced. A second function of the Core H&W Service will be **Community asset building:** working with and for communities to support them to identify their own needs and assets and to build their own capacity to be resilient and self-supportive. This will include helping to strengthen the local community and voluntary sector to enable it to provide a lot of the support

		services at a local level.
26	Is the networks focus information sharing and/or providing support services through peer support, one to one etc?	Please see above
27	Where can mandatory training be built into specifications? Should it be built in separately or will they be covered through the outcome measures?	The proposed (core) Health and Wellbeing service will have a capacity building and training function. The reach and participation in this will potentially be extended through the network of linked services and providers who could offer access to and/or delivery of parts of the training offer.
28	For Clinical Pathways and Health and Wellbeing Services, there needs to be explicit and specific outcomes for carers	This has been noted in both the clinical engagement and the City Councils consultation programmes. The pathway to Health and Wellbeing recognises and seeks to build on and support where appropriate, the role of carers
29	Housing benefits is often an issues - MCC Customer Services Centre needs to be linked into the new model. Also how will Health and Wellbeing network feed into support through residential social care and home care?	The core Health and Wellbeing Service will be surrounded by a range of other services – not necessarily commissioned by MCC – that will offer referral to the service, and/or specialist or locally based support. The aim is for many of these services to become accredited as part of a Health and Wellbeing Network. Accredited services will be able to • sign people up as members of the Network directly (rather than through referral) via an online mechanism; • carry out all or part of a common assessment to support the identification of individual needs and assets and the development of an individual plan; • provide some specialist or local services and give access to others that are part of the network; • record outcomes for clients as part of a common approach to outcome monitoring; • utilise communications channels with Network members.
30	Peer Support has a place in the recovery process, however we believe this would be more appropriate when services users have the emotional resilience to live independently in the community or accessing floating support	We will be continuing to work with stakeholders to develop the core Health and Wellbeing Service specification, ensuring that the requirements around peer support are included. This will be further developed through the tendering and contracting process to ensure that the delivery and infrastructure support is in place and implemented at the appropriate stages in recovery.
31	Peer support needs investment and infrastructure and shouldn't be viewed as a cheaper alternative	We agree and as part of this consultation programme a development session on peer support was facilitated by Macc (via its Recovery Network) to explore this further – see consultation report for more details. The plan is to take this work forward and to invest in peer support and infrastructure support as part of the proposed core Health and Wellbeing service specification.

32	Peer supporters need specialist support in order to provide support to their peers. It is wrong to counterpoise peer support and specialist support services and suggest that funding can be taken from the latter to pay for the former.	We recognise that individuals need a range of support to get them to a point to be ready to deliver peer support. Our intentions are to develop peer support as a key component of the recovery model. This will offer opportunities for service users to take an active role in helping others as well as themselves.
33	Model – Concern that GP's would not be able to consistently deliver in this model. Do we need to consider alternatives?	The proposed Health and Wellbeing model is not being built specifically around GP's but as a potential network and referral route that GP's and other partners could link into and use.
34	Stronger Health and Wellbeing links needed - GP's not having the time to refer even. How can this be built/linked to the Lifestyle role?	The one to one 'Lifestyle' role being developed as part of the proposed Health and Wellbeing Service could potential provide an initial level of holistic support for individuals which would look at housing, benefits, as well as the mental and physical health of the individual.
35	Model – Who will determine the needs? - People present with wants not needs. Realistic expectation needed	The core Health and Wellbeing Service being proposed will operate a triage function, with further assessments conducted based on need and access to specific service support.
36	Mental health interventions need to be sequential so that there is a step change to enable people to live independently and are able to sustain this in the long term.	The proposed Health and Wellbeing pathway forms part of an integrated 'whole system' approach which recognises the need for individuals to have sequenced interventions and to step up and down from care as part of their recovery.
37	VCS orgs - quality, monitoring and impact not known and as robust as the expectations placed on statutory services. Whilst this is understandable to an extent, how do we know that we are getting value for money and whether they are more or less important?	The current VCS services funded through the Council are monitored and reviewed. Our vision is for a mental health service system within which all providers (whether statutory, independent or third sector) focus on seven success criteria for a good quality mental health service: 1. Health Outcomes 2. Social Outcomes 3. Community Safety Outcomes 4. Choice and Relationship Outcomes 5. Physical Health Outcomes 6. Fair and Straightforward Access 7. Value for Money
38	Where does childhood obesity fit in with this model?	The proposed Health and Wellbeing Service will be for ages 18+ but with an understanding that there is a need for services to take an holistic approach to people and families. The Health and Wellbeing Service The pathway will be closely linked to the childhood obesity care pathway and also to Troubled Families interventions such as the Family Intervention Project.
39	Could some of the current Public Health funded physical activities be merged or linked closer together, to bring efficiencies?	The Physical Activity Referral Service (PARS) will be merged with the City Councils Active Lifestyles service. This physical activity service will be provided by the City Council and efficiencies will be made.
40	There is a list of current services but not a	A review of the city's lifestyle and wellbeing services

	full description of the current model (Public Health) and the call for change. How does this link with the options paper previously done by Public Health? The engagement thread from that process needs to be recognised and fed into this current thinking	has been underway since the transfer of Public Health to the City Council. This review process has included widespread informal discussions with commissioning partners, providers and the community and voluntary sector during summer and autumn 2013, and as part of the formal consultation on the pathway to Health and Wellbeing November 2013 to February 2014. Wide ranging views and responses have been received to this review process, and design of a new model is now nearing completion.
41	What current (Public Health) services are in and out of scope as part of this redesign?	Apart from PARS all services currently provided by the Public Health Development Service are in scope.
42	Overall the consultation document seems to be almost entirely about wellbeing services for individuals...There is no mention about the importance and need to build capacity in organisations (service providers, employers, voluntary sector organisations etc)…Nor is there anything about community development…	The third function of the Core H&W service is **Training and infrastructure development:** building an accredited network of organisations that are able to be part of the overall healthy living system in the city. This will include training front line staff in basic health behaviour identification and brief interventions, providing more in depth training on key topics, establishing assessment and referral mechanisms with partner organisations, and encouraging these organisations to provide appropriate services. A second function of the Core health and well-being Service will be **Community asset building:** working with and for communities to support them to identify their own needs and assets and to build their own capacity to be resilient and self-supportive. This will include helping to strengthen the local community and voluntary sector to enable it to provide a lot of the support services at a local level.
43	Ref to 1.7 of Commissioning Intentions - Would be useful to share information such as the quality of services, cost analysis that has been collated through the review of supported accommodation, more specifically for mental health services which has not been discussed widely with service providers	Where possible and appropriate, we will share information with stakeholders including reviews of services. This will also be used to inform future plans and decisions making.
44	More of an outreach element is needed particularly for those minority and marginalised groups to access	We are looking at ways that the proposed Health and Wellbeing Service can deliver services within the community through outreach, one to one, peer support and links to accredited network providers.
45	How will groups such as homeless, people with problem drug use etc be reached and accommodated?	We will work with partners including Voluntary Community Sector organisations, Housing providers, GP's, the Police, Job Centres etc to develop links and referral pathways into the proposed Health and Wellbeing Service. The service will also be made available via a telephone line and website, for self-referral and support with self help
46	Can we build on Neighbourhood Teams in	Yes, the proposed Health and Wellbeing Service will

	North?	have a citywide remit and will be based in different geographical areas in order to build community links and meet local needs. Where possible and appropriate we will look to co-locate staff and services and utilise existing neighbourhood structures and teams to deliver the service.
47	How can the H&WB service work with and on alternatives to GP's being the main point of referral? (Sometimes other VCS groups/Specialists Support Groups have a better understanding of the needs and issues that need to be address as part of the care/treatment)	The proposed Health and Wellbeing Service aims to bring support services together at a local level, promoting opportunities for sign posting and referral. The role of VCS groups is recognised as an area that can be developed further to support individuals and to provide alternatives to treatment or support for individuals that are waiting for treatment.
48	Does the alliance model being developed for the commissioning of some supporting people funded services provide an opportunity for housing organisations to come together at a neighbourhood level and take responsibility for the delivery of wellbeing services? Can the consultation exercise provide the opportunity to explore the use of this model in this context?	The specification for the proposed core Health and Wellbeing Service will be seeking a provider to cover the city. The alliance and other interested parties will be open to tender for this. Whilst the consultation has ended, the commissioning team are keen to continue to discuss potential neighbourhood links to the proposed Health and Wellbeing Service and wider network. Please contact Sonia Andrade Associate Director Public Health Manchester Tel. (External) 0161234 3523 email s.andrade@manchester.gov.uk Michael Salmon Commissioning Manager Direct Line: 0161 234 4557 Mobile: 07984158643 Email: m.salmon@manchester.gov.uk
49	Health and Wellbeing services encompass more than the services commissioned by Public Health. Will all the services need to be accredited before people can be sign posted to them?	Please see response to question 30
50	How would an independent self-help group gain accreditation for example?	Please see response to question 30
51	Who will quality assure the network?	The proposed core Health & Wellbeing Service will under its Training and infrastructure development function.
52	KPI's - who would measure or gain data on improved health?	The KPI's and other outcome measures will be detailed in the final service specification.
53	How would proposed kite mark scheme operate?	Please see response to question 30
54	Who will be responsible for setting quality standards for kite mark?	Please see response to question 30

55	What would happen if services did not sign up to the kite mark scheme but were accredited to some other national standard?	Please see response to question 30
56	What are the quality standards and will they be based on NICE guidance?	The quality standards will be detailed in the final service specification and, where applicable, will adhere to NICE guidance.
57	It would be useful to have one central hub to deal with all mental health provision within the City. This may be an opportunity for the future with the joint commissioning approach with CCGs and Manchester City Council and will enable better interfaces between health, social care and Supporting People.	The City Council and CCG's are committed to working together through the Living Longer, Living Better programme which aims to accelerate progress on better integration of services for Manchester residents. A variety of options and opportunities will continue to be explored in order to achieve this.
58	Physical and mental health assessments often do not come together. What can be done through commissioning to address this?	Where we are commissioning and/or working jointly with other commissioners of physical and mental health services, we will influence and utilise opportunities to bring assessments and support packages together. Some of this could potentially be realised through the delivery to the proposed Health and Wellbeing Service which will take a holistic approach to the individual service users needs.
59	From a service user/carer perspective, the recruitment of professionals is key. Often those that have had personal experience within mental health understand and provide a better level of service	Where possible and appropriate we will build this into service specification documents.
60	Website access creates a danger that the model will reach the ones that aren't in the most need	The proposed Health and Wellbeing Service will have a number of access routes including telephone line and website.
61	Need to consider the management of self-referrals - This could increase demand. Triage function definitely needed	The proposed Health and Wellbeing Service will include a triage function in order to manage referrals and demand. The service will combine self-help information, tools, with directly delivered service support and links to network of providers.
62	Age range will impact on the delivery of the model, particularly the lower age range limit and all of the work needed around transition (young people)	As the Council develops an all age approach, mental health services for children and young people are being reviewed to ensure that the services provided mean that more children and young people will have the positive start in life needed to experience good mental and wellbeing over the life course. This approach reflects the overall aim for citizens of starting well, developing well, working well, living well and ageing well.

Recommendations

1. **Recommendations for individual pathways and whole system**
   Mental Health Strategies have conducted detailed analysis on all of the feedback from across the spectrum of engagement. The feedback has been themed and the information is shared on page 36.

2. **Forward plan reporting, feeding back and opportunities for future involvement**
   Many respondents have been unequivocal about the level of feedback and involvement that they believe is appropriate with some even asking for invitation letters direct to each event attendee detailing the number of recommendations received, along with the number accepted for inclusion in future specifications.

   It is up to the Mental Health Improvement Programme team and the engagement steering group to decide on the appropriate level and detail of feedback, however it is recommended that the Mental Health Strategies analysis of feedback is made available to anyone who requests it.

   Copies of this engagement report will be available in both paper and electronic formats.

   If an event attendee shared their email address with us, an electronic copy of this report will be emailed out with the option to receive a paper version of this report.

   Electronic versions of the report will also be posted on the Clinical Commissioning Groups website as well as partner organisations websites.

   Links to this report will be shared through our Talking Health e-bulletin, through our social media platforms and those of partners and stakeholders.

   Paper copies of this report will be circulated to mental health service user and carer groups.

   Requests for this report to be translated into another language can be emailed to **talkinghealthmanchester@nhs.net** or a telephone request made to 0161 765 4004.

   Further, careful consideration should be given to what future opportunities may exist to involve service users, carers and their representatives in the next stages of the procurement process.

   Particular regard should be paid to nurturing relationships between service users groups, carers, commissioners and providers and how to effectively involve service users, carers and their advocates in key decisions.

   Additionally, an accessible (preferably visual) future timeline should be produced, detailing the key decision points between now and the roll out of the new system and describing the opportunities for patient, carer and public involvement for each.

3. Development of engagement co-production model

One of the most successful aspects of the engagement programme was the development of the Macc 'facilitation offer'. Whilst it was not a cheap option, there is a clear argument that it was good value for money in that it produced a greater range and depth of responses than more traditional NHS local engagement exercises have in recent years.

The deployment of independent facilitators offered engagement capacity far in excess of any available in-house and ensured that people felt free to express their opinions in an unbiased way. It is recommended that a more detailed write-up of this process is undertaken with a view to developing this as a model for future large-scale pieces of engagement in the city.

A debriefing meeting with the independent facilitators who delivered the Macc facilitation offer was held on 1st March 2014. The feedback below was received on the process and ways in which it might be improved for the future.

All future engagement events in Manchester will be following the co-production guidelines as set out in the on-going Living Longer, Living Better process.

4. Positive aspects

Overall the process had a demonstrable influence in improving the service specification. Host groups and participants were very positive about the opportunity, and for many this was the first time they were asked to contribute. Host groups existing knowledge and relationships maximized engagement. Host groups language skills were vital for translation. The events themselves helped participants to break stigma as these issues aren’t talked about. Participants’ confidence was raised by attending meetings.

There was a high quality of responses where groups and participants were more knowledgeable and confident. The focus on indicators as well as outcomes helped to make it a real for groups and participants. The joint planning meetings helped to create a sense of ownership of the events.

Facilitators were able to be flexible with methodology to respond to different needs:

- One group set out a plan for whole new Learning Disability service but was in a diagram (yet to be submitted)
- One group used one to one interviews as participants were unable to work effectively in a group
- One group focused on one simple question and used a more visual approach
- Community conversations and thought showers

People were realistic over outputs - aiming for 'getting up in the morning' or 'able to meet others’. Not so much about 'getting better, more about managing and 'autonomy' - feeling in control.

5. Challenges

- Keeping on track with interpreted events was a challenge as conversations take longer. Each event was different so it was difficult to maintain consistency in reporting.

- Time was an issue, and all events were affected by the tight timescales and this was felt more so with groups of people whose needs were more complex e.g. those with a learning disability or alcohol issues, where English was not their first language (no word for wellbeing in Cantonese) or unfamiliar with commissioning processes. Due to the mixed needs and abilities of participant groups, facilitators needed to strike a balance between the time needed to explain and set the context and allowing enough time for people to have the discussion and get their voice heard. The timescales also limited the time available for Mental Health Strategies to analyse the findings.

- The online Survey monkey layout was not user friendly for reporting back on engagement events - text boxes too small and the system did not allow for submission of images, formatting and context.

6. Proposed Improvements

- Use a different system (e.g. word document template rather than survey monkey) for reporting
- Have the timeline before events, so that facilitators know how feedback will be managed
- More briefing detail needed for facilitators on what the Clinical Commissioning Groups want and how to ask the questions
- Need to ensure that we use multilingual facilitators in future or allow more time for preparation in the planning stage to ensure that the groups understand what the commissioner's want so that the conversations stay on track.
- Helpful to call it an engagement process, but that needs follow-up over a period of time
- There may be findings that Clinical Commissioning Groups won't take on but the voluntary and community sector could be working on in terms of wellbeing and this may indicate a support need around product development

7. Recommendations for a different process

Hold an initial briefing meeting for groups and facilitators, including a needs assessment to place groups in one of three *bandings*:

- **Band one (reimburse)** - groups with capacity and specialist knowledge/skills run event themselves with minimal input from facilitator for independent verification (group receive facilitation payment to cover costs)

- **Band two (support)** - facilitation provided for planning facilitation and report writing where group lacks capacity. Group will still input into planning and may provide interpretation

- **Band three (provide)** - greater level of support from facilitator/s where groups have more complex needs and less understanding of commissioning (groups would receive more intensive practical support in planning, delivering and reporting on engagement)

Also identify potential opportunities for joint planning and or holding joint events, where viable, for groups that are tackling similar issues or have similar support needs around engagement.

Choose from a menu of methodologies:
- Community development process
- Programme of focus groups
- Community reporters
- Themed Charter Alliance meetings
- Discovery Interviews
- Other

Next steps

I would like to pass on my thanks to people who attended the engagement events and who took time to comment on the care pathways via survey monkey, or via email.

The comments received have been very helpful and have shaped the final care pathway document, which was presented to North, South and Central Manchester Clinical Commissioning Group boards, and Manchester City Council's Senior Management Team, throughout March 2014.

The three Clinical Commissioning Groups have approved the use of the 17 care pathways as the basis for the commissioning of future mental health services in Manchester.

An executive level partnership group has been established between Manchester Mental Health and Social Care Trust; Manchester City Council; North, South and Central Clinical Commissioning Groups and the Trust Development Authority.

In recognition of the required large scale service transformation that the mental health improvement programme brings, and the associated risks, the group are progressing discussions in order to determine the available options for how the mental health improvement programme can be delivered.

The timetable for the implementation of the Mental Health Improvement Programme and a new communication and engagement plan will be finalised and shared with stakeholders, once the partnership group, outlined above, reaches a conclusion.

In the meantime, the Mental Health Improvement Team continues to welcome comments and participation, so please do get in touch by email via **talkinghealthmanchester@nhs.net** or by calling **0161 765 4004**.

Jane Thorpe
Head of Mental Health Improvement Programme

Conclusion

The overall engagement programme was broadly successful in raising awareness of the proposals and in gathering patient, carer and stakeholder feedback. The mix of engagement opportunities produced in excess of 1,000 individual comments that will be used to inform 17 clinical pathways and an as yet undetermined number of service specifications.

The 'facilitation offer' developed in partnership with the voluntary and community sector is of particular significance. This approach allowed local groups to work with their own members and gather responses on their own terms, producing highly relevant and apposite responses from a wide range of people.

There is a need for future engagement activities to include partnership working with Manchester Mental Health and Social Care Trust and other providers to ensure inpatients are engaged with, have the opportunity also to share their views and be listened to.

Your opportunity to join in and get involved

We want people to be involved as much as possible in every decision about their care; what care they want, and how and where they want it delivered. This will mean service users, carers, health and care professionals, and commissioning organisations such as ours genuinely making decisions in partnership.

There are a number of ways you can do this:

- Join our Patient and Public Advisory Groups
- Join our Manchester Expert Panel
- Keep a patient / carer diary and share your experiences of using local NHS health services
- Share with us your service user / patient / carer experiences
- Receive our Talking Health e-bulletin

If you are interested in any of the above opportunities, you can telephone **0161 765 4004** or email **talkinghealthmanchester@nhs.net .**

www.twitter.com/ManchesterCCGs

http://www.pinterest.com/nhsinmanchester

Do you have an enquiry, compliment or complaint?

If you are have an enquiry, compliment or complaint about your GP practice, you should first ask to speak to the Practice Manager. If your issue cannot be resolved by speaking to the Practice Manager, you can contact the NHS England Contact Centre.

If you have an enquiry or complaint about GPs, dentists, opticians or pharmacists you should contact the NHS England Contact Centre.

Telephone: 0300 3112233
Email: **england.contactus@nhs.net**
Write to: NHS Commissioning Board, PO Box 16738, Redditch B97 9PT
Website: www.england.nhs.uk/contact-us/complaint

Opening hours 8am to 6pm - Monday to Friday excluding bank holidays.

If you wish to contact the NHS North, Central or South Manchester Clinical Commissioning Group about a service they commission (purchase), you should contact Patient Services.

Telephone: 0161 212 6270
Email: **patientservices.gmcsu@nhs.net**
Write to: 3rd Floor, St James House, Pendleton Way, Salford, M6 5FW

Opening hours 9am to 5pm - Monday to Friday excluding bank holidays. A confidential answerphone is available outside these times.

How can I get help to make a complaint?

Some patients require help and support to make their complaint. The Independent Complaints Advocacy (ICA) service provides advice on how to make a complaint, empower patients to make their complaint and where necessary support at local resolution meetings. The contact details for ICA are:

Telephone: 0808 801 0390
Email: **boltonica@carersfederation.co.uk**
Write to: 5th Floor, Arthur House, Chorlton Street, Manchester, M1 3FH
Website: **www.carersfederation.co.uk**

HealthWatch Manchester

HealthWatch Manchester is your local consumer champion for health and social care.

Telephone: 08444 170 411 (helpline)
Email: **info@healthwatchmanchester.co.uk**
Website: **http://www.healthwatchmanchester.co.uk**