Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 18th September 2013

Subject: Mental Health Commissioning Intentions

Report of: Chief Clinical Officer, North Manchester Clinical Commissioning Group
Strategic Director, Families, Health and Wellbeing

Summary

This report summarises for the Health and Wellbeing Board the overall approach to the commissioning of mental health services by the three Clinical Commissioning Groups (CCGs) in Manchester and Manchester City Council. The supporting documents attached to this paper are:

- The commissioning intentions for partnership commissioning between the Manchester CCGs and City Council (Annexe 1)
- The commissioning intentions of the City Council as a single commissioner (Annexe 2)

Recommendations

The Board is asked to:

i) Note the contents of the report
ii) Endorse the approach being taken by commissioners to develop commissioning intentions for mental health services

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Board Priority(s) Addressed:

All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above

NHS Manchester/Manchester City Council – Mental Health Independent Report. Final Report – April 2013

Post Mental Health Independent Report – Action Plan 2013

Introduction

1.1 The Health and Wellbeing Board identified mental Health as one of the eight key strategic priorities for Manchester. One of the key roles of the Board is to ensure the commissioning plans of the CCGs, Council and other partners reflect these priorities. This report therefore summarises the overall approach to the commissioning of mental health services by the Clinical Commissioning Groups (CCG) in Manchester and Manchester City Council (MCC). This will then drive the commissioning strategy for these services, including priorities for change in service delivery, distribution of resources, and the management of the local market for mental health service provision.

2.0 Background

2.1 Mental health is an essential and cross cutting element of the Living Longer, Living Better (LLLB), programme and a very important issue in Manchester - both 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.

2.2 Commissioning intentions have been developed in light of a number of significant changes taking place following the Health and Social Care Act 201,2 which are changing the landscape and commissioner expectations of how services will be commissioned in the future including:

- The establishment of CCGs from April 2013 which gives GPs overall responsibility to commission health related mental health services.
- The disestablishment of the Mental Health pooled fund arrangements in March 2013 which means that the Council now has a direct commissioning relationship with Manchester Mental Health and Social Care Trust (MHSCT).
- From April 2013 Public Health funding and responsibilities transferred to the City Council.

2.3 The commissioning intentions have also been informed by the recent independent review into the mental health system in Manchester and other reviews and reports over the last 10 years. The Manchester Health Scrutiny Committee and CCG Boards have all received and discussed the recent Independent Report and its findings and considered the immediate actions being taken to secure improvements across the system.

3.0 Health and Social Care Joint Proposed Commissioning intentions

3.1 The following commissioning intentions have been developed between the CCGs and Manchester City Council in terms of a one system approach to mental ill health. As stated earlier mental health is an essential element of the LLLB programme that cuts across all the priority population groups both 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. Commissioners in Manchester, across health and social care, spend around £100 million each year on mental health services and provision, expenditure for which we must ensure the best possible value for money. The summary breakdown of this investment is presented in table one below.

Table One

Organisation	Activity	Annual Funding
CCGs	Health Interventions	£84,038,000
CCGs	VCS	£ 7,296,000
MCC	Social Care	£13,360,000
MCC	VCS including carers	£ 700,000
MCC	Supporting People	£ 3,450,000
MCC	Public Health Mental Health Promotion	£ 171,687
	TOTAL	£ 109,015,687

3.2 The intentions must address the range of concerns about current mental health services highlighted in the recent independent report and previous reports including:

- Services for adults of working age experiencing severe mental health crises. Too many people have to wait too long to access the services they need, or are sent to services a long way from Manchester
- The interfaces between the various services and providers do not work as well as they should, and care arrangements are therefore not as seamless as we would wish
- We wish to develop a stronger emphasis on and support for recovery and prevention of readmission
- We think there could be better approaches to the management of risk within mental health services, with greater learning from untoward incidents which happen
- The balance of services between age groups is currently not well aligned to the pattern of local needs
- Arrangements for accessing services are not well coordinated between providers
- Mental health services are not as integrated with acute and general healthcare as we would wish

3.3 Jointly we intend to move towards an outcome-based approach to commissioning mental health services and is closely linked to LLLB. 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

3.4 This approach will introduce a new and very different approach to provider accountability. Providers will be required, via regular performance reports, to account with detailed evidence for how they are acting to achieve the seven success criteria, and for how they plan to address any identified shortcomings. We will develop these accountability frameworks jointly across health and social care, to ensure consistency and continuity of performance management arrangements. This will therefore build into a new framework of performance indicators, developed between ourselves as commissioners, and our service providers. We will then expect to see regular improvements, year-by-year – both in the detail and meaningfulness of the data being presented, and in the levels of performance being reported.

3.5 In the short-to-medium term, we additionally intend to address six key service improvements:

a) Ensuring that the acute care pathway is fit for purpose
b) Developing more formal understandings and structures around service interfaces, access, and care pathways
c) Agreeing the principles of risk and recovery management
d) Formalising the sharing of information with providers
e) Improving the integration of mental and physical health care
f) Improving links between the statutory and voluntary sector in mental health

3.6 As regards procurement arrangements, we envisage moving towards an approach to adult mental health services which reintegrates most (but not necessarily all) healthcare services into a single mental health system contract for mental health services, to be provided either directly by a single provider, or to be subcontracted as part of a lead provider arrangement. In determining exactly which services should be reintegrated, we will consult with the organisations currently and potentially affected, and with other local stakeholders. We will also consider whether, and to what extent, any social care services might be rolled into this single contract arrangement.

4.0 Manchester City Council Proposed Commissioning Intentions

4.1 These commissioning intentions complement those set out above and reflect Manchester City Council's broader role in terms of the mental wellbeing of citizens with a focus on resilience of both citizens and communities. However, it is our intention that these commissioning intentions will be further aligned and integrated over the coming months.

4.2 As stated earlier Manchester City Council now have a direct contractual relationship with MMHSCT. Mental health services will also integrate within

LLLB and provide support to other areas of Public Service Reform. Public Health also now sits within the Council, which has a broader remit in terms of mental wellbeing across Manchester's citizens. This gives us an opportunity to commission services in a different way across the population within our communities and also through the linking of investment into severe and enduring mental health need to public health provision, for example, lifestyle services.

4.3 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. There will be a greater emphasis on helping citizens to gain employment through education, training and voluntary opportunities on the basis that good work is good for mental health. Better integration of employment and mental health services is key to this. These intentions are set out in full in Annexe 2

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4.4 Manchester City Council and the CCGs remain committed to working together to join up commissioning activity to cover the broad spectrum of a lower level preventative approach. This will give a greater focus on mental wellbeing as well as strengthening recovery oriented services for people with more acute mental ill health.

4.5 Manchester City Council is also committed to commission services across the life course and as such commissioning intentions for children and young people are currently under development. We will be working closely with the CCGs to produce these jointly in the coming months.

5. Recommendations

The Board is asked to:

i) Note the contents of the report
ii) Endorse the approach being taken by commissioners to develop commissioning intentions for mental health services

Annex 1

The Commissioning Intentions for partnership commissioning between Manchester City Council and the CCGs Central, North and South Manchester Clinical Commissioning Groups & Manchester City Council commissioning intentions for mental health services (DRAFT)

1. Introduction – purpose and structure of document

1.1. Purpose of document

This document is intended to set out and confirm the overall approach to the commissioning of mental health services, in order to guide decision-making about:

- The **commissioning strategy** for the services within the scope of this document – the type of services we aim to commission, and how we intend to commission them
- **Priorities for service change**, service redesign and service reconfiguration – aspects of mental health services that we would wish to see improve
- **Patterns of investment** and distribution of resources in mental health services – how we will use our commissioning resources to secure the best value for money
- The **management of the local market** for mental health service provision – decisions about how we procure services, and the way we hope to see the local market develop for mental health care

It is not intended to provide a detailed specification for services at this stage, nor a detailed financial investment plan. Those will be developed within the framework provided by these overall commissioning intentions.

1.2. Scope of services affected

These commissioning intentions will drive our approach to commissioning the following services, across health and social care:

- Child and adolescent mental health services, including16-17 year old services, (tiers one-three only, that is community-based services)
- Mental health services for adults of working age, including both primary and secondary care mental health services. This includes the early intervention in psychosis and criminal justice services currently provided by providers not based in the city of Manchester
- Mental health services for older people, both services for people with dementia, and other mental health problems
- IAPT services – improving access to psychological therapies
- Mental health services for adults with a learning disability

These commissioning intentions do not directly affect the specialist mental health services which are now commissioned directly by NHS England, including forensic mental health services, prison healthcare, and tier 4 (inpatient) CAMHS services. We will continue to work closely with colleagues at NHS England to ensure effective care

pathways between locally and nationally commissioned services; and to identify opportunities to achieve overall efficiencies for the public purse by commissioning less intensive services in order to reduce demand for more intensive services.

NHS England are also now responsible for commissioning primary care services; this is not our direct responsibility as local commissioners. We will however clearly plan to commission mental health services which integrate successfully with services provided directly within primary care, in particular general medical practice; and to ensure that support is available to practices to develop their skills and relationships in mental health work.

1.3. Structure of document

After this introduction, this document is organised as follows:

- Section 2 sets out the overall vision for Manchester's mental health services – the outcomes we are seeking, and the main changes we think are required
- Section 3 explains the implications of this vision for the provision of mental health services in Manchester
- Section 4 then describes what will happen next once these commissioning intentions are formally adopted

2. Our overall vision for Manchester's mental health services

2.1. Context – the importance and performance of mental health services in Manchester

Our "Living longer, living better" strategy commits us to developing a health and social care system in Manchester within which:

• "We will keep learning about your needs, the services and the community where you live to ensure we base decisions on up to date knowledge and evidence.
• We will co ordinate care and design services around you and as close to your community as possible.
• We will organise our health and social care system so it is right for you, your community and Manchester.
• We will create a workforce which is centred on promoting your well being and whose goal is to help you to live longer and better.
• We will ensure that resources are spent wisely, targeted where they are needed and where they can make a difference, working together to change the way resources are shared.
• We will have up to date information that we can share with you and can be accessed at the right time and right place between the right people.
• We will aim to co ordinate care around you and bring it together in facilities in your community when appropriate.
• We will listen to you, talk to you and together positively change care in Manchester

Mental health is an essential element of the "Living longer, living better" strategy, and a very important issue in Manchester - both 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.

Mental health problems affect a great many people in Manchester; around two thirds of GP consultations have the patient's mental health as an important component. At any one time, we estimate[1] that:

- Over 68,000 adults have some form of common mental health problem, such as depression, or anxiety
- Around 2,000 adults have schizophrenia
- Over 6,000 adults have a bipolar disorder
- Around 3,300 older people have a form of dementia, a number which will rise significantly as people in our community are living longer
- Over 6,000 children and young people have a mental health problem

Beyond the person directly affected, these problems also affect families, carers, friends, and colleagues. Mental health problems also often lead to or worsen the effects of physical health problems.

Many factors contribute to good mental health: good relationships with our friends and family, work or other useful activity, exercise and a healthy diet, access to green spaces, enough money to achieve an adequate standard of living. Both Manchester City Council and the three CCGs greatly value work which is undertaken to improve the lives of the people of Manchester and to promote their mental wellbeing by working on these issues.

This vision is however for our system of mental health ***services*** – the range of treatment, care and support which is available to people experiencing periods of mental illness. These services are currently provided in Manchester primarily by the Manchester Mental Health and Social Care NHS Trust, for adults, and by Central Manchester NHS Foundation Trust for children and adolescents, each of which provide a range of different services for their respective age group. There are, however, several other providers, the largest of which are:

[1] *Mid-2011 Population Estimates for Primary Care Organisations, based on the results of the 2011 Census (Office for National Statistics)*
Common Mental Health Disorders / Personality Disorders - *Adult Psychiatric Morbidity Survey (NHS IC, 2007)*
Psychotic Disorders - *Paying The Price (King's Fund, 2008)*
Dementia - *Dementia UK: The Full Report (Alzheimer's Society, King's College London, LSE, 2007)*
CAMHS Disorders - *Mental Health of Children and Young People in Great Britain (Office for National Statistics, DH, Scottish Executive, 2004)*

- Rotherham, Doncaster and South Humber NHS Foundation Trust (early intervention in psychosis)
- Self Help Services (psychological therapies)
- Greater Manchester West Mental Health NHS Foundation Trust (offender healthcare)

There are many strengths to local services, and many clinical, professional and other staff providing care and treatment which is effective, and valued by their users. We in turn value the work of these staff, and we will work to ensure local strengths and skills are protected and developed. However, we have concerns as responsible commissioners about several important aspects of the way mental health services work at present:

- We are particularly concerned about services for adults of working age experiencing severe mental health crises. Too many people have to wait too long to access the services they need, or are sent to services a long way from Manchester
- The small number of wards to which Manchester patients have routine access does not promote the development of local specialist wards for specific patient groups
- The interfaces between the various services and providers do not work as well as they should, and care arrangements are therefore not as seamless as we would wish
- The need to improve support for our large student population
- We think there could be better approaches to the management of risk within mental health services, with greater learning from untoward incidents which happen
- We wish to develop a stronger emphasis on and support for recovery and prevention of readmission
- The balance of services between age groups is currently not well aligned to the pattern of local needs
- Arrangements for accessing services are not well coordinated between providers
- Mental health services not as integrated with acute and general healthcare as we would wish

This vision therefore aims to create a framework which will:

- Preserve the good practice which is currently available in Manchester
- Address the issues and concerns which we identify later in these intentions
- Move Manchester's mental health services towards the standards of the best in England

These commissioning intentions will also ensure local implementation in Manchester of the principles of the mandate which was agreed in November 2012 between the Department of Health and NHS England. This included as key commitments:

- Delivering a service that values mental and physical health equally

- Supporting people to take personal control of long-term conditions
- Continuing to improve access to psychological therapies
- Addressing delays in waiting times for access to mental health services
- Improving the diagnosis, treatment and care of people with dementia
- Supporting families and carers

We are confident that these commissioning intentions will support our work to ensure that these commitments are achieved in Manchester.

2.2. What mental health services should be working to achieve

Commissioning of mental health services has traditionally focussed on the **volume** of services provided – the number of admissions to hospital, or outpatient visits, or contacts with a community team. Whilst this approach has enabled us to understand the **output** of services (how much they are doing for the money we provide) it tells us nothing about their **outcome –** how mental health services are improving the lives of the people who use them.

This now needs to change, and our intention is to move the focus of our commissioning on to the outcomes which mental health services achieve. In mental health, good outcomes mean:

- For the person using services, either recovery from illness, or the best possible quality of life and independence, despite continuing illness
- For family and friends, the best possible quality of their own lives, whilst caring for a person with mental health problems
- For the whole community, people with experience of mental illness contributing positively to community life, through minimised risk, through work, and through social roles and activities
- Improved mental wellbeing and resilience for the whole community

All of this will be in the context of the national outcomes framework for mental health services, set out in "*No health without mental health*", which identifies as outcome domains for mental health services:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Our vision is therefore for a mental health service system within which all providers (whether statutory, independent or third sector) focus on the following seven success criteria, which together cover the spectrum of what it means to provide a good quality mental health service:

<u>1. Health Outcomes</u>
This should mean, for most people, reducing the symptoms they experience, such as anxiety, or problems with their memory or their thinking, or more severe problems

such as hallucinations or hearing voices. People should see improvements in their ability to function, and a better mental state. For some people, whose mental health problems are most severe, a good outcome may mean supporting them to maintain the best possible quality of life despite continuing illness.

2. Social Outcomes

People with mental health problems have the same sort of aspirations for their lives as people without: good relationships with friends and family, somewhere pleasant to live, enough money to live on, and contributing to their community through education, work, or other roles within the family. Good mental health services should support people to maintain as much as possible of the lives they already have; or support them to regain the best possible quality of life after a period of illness.

3. Community Safety Outcomes

People with mental health problems face far greater risks themselves than any they present. Good mental health services should work to ensure that people who use them are at the lowest possible risk of suicide, deliberate self-harm or self-neglect. This means providing the right level of care and support, either in the community or as an inpatient to reduce avoidable harms to the absolute minimum. A very small minority of people with mental health problems do also present a potential risk to the safety of other people; good mental health services will also take responsibility for managing and minimising these risks.

4. Choice and Relationship Outcomes

For all health services, it matters greatly that people who use them feel that they have been provided in a way which respects and informs their choices and preferences, and that they have a good relationship with the staff of the service. For mental health services, this is especially important, as poor relationships between staff and service users risk poor outcomes in other areas. People who use services should feel able to recommend those services to friends or family who also need similar services (the “friends and family” test.)

There is also an important and related dimension to this, in the way in which mental health services work with partner organisations. Good mental health care relies on a complex web of relationships: with social care, with primary care, with the criminal justice system, with the voluntary sector, with providers of acute and community healthcare and so on. Good mental health services will achieve strong relationships across this network of partner organisations, in the interests of all of their users.

5. Physical Health Outcomes

People with serious and enduring mental health problems are at far greater risk of long-term physical health problems, such as cardiovascular disease and diabetes, in part as a result of poverty, or of less healthy lifestyles, but in part also as a result of the effects of their medication, or of difficulties in accessing the relevant health services. Good mental health services should play a full part in supporting people with whom they work to gain access to all the health services they need, and to maintain a healthy lifestyle despite their mental illness.

In addition, people with long-term physical health problems are at much greater risk of developing common mental health problems such as anxiety or depression.

Mental health services should work with partners in general community services to ensure that these problems are treated in a coordinated way.

6. Fair and Straightforward Access

Access to mental health services should be fair, across age groups, across areas of Manchester, and for Manchester's many diverse communities. We therefore expect providers of mental health services to consider and to demonstrate how they provide those services in ways which reflect and respond to the differing needs of these groups and communities.

Access should also be straightforward, both for people approaching services directly, and for professional referrers. This requires clear communications, passing and receiving information in a clear and structured way, and effective systems for handling and triaging people according to need.

7. Value for Money

All of the above six things should be achieved within costs which are comparable to the typical cost of good quality mental health services elsewhere in the country. This will initially mean cost per unit of output, but should over time increasingly mean cost per outcome achieved.

For an individual person using services, their experience of a service which is doing well against all of these criteria could look like this:

- "The treatments I received really worked for me. I feel a lot better, and I'm able to get on with my life"
- "The service helped me to get things back together, to sort out my benefits, and then to get me back into a job"
- "When I was wanting to harm myself, the service worked with me to manage my feelings and my behaviour, so I stopped"
- "I really liked the staff who worked with me, we got on really well, and I'd recommend them to anybody"
- "I was able to get to know the people who provided my care, and they got to know me."
- "The mental health team worked with my GP and my community nurse to coordinate things. Everyone always knew what other people in the team had been doing"
- "I always knew what was happening with my referral – and I didn't have to wait too long to be seen"

This approach will introduce a new and very different approach to provider accountability. As part of our commissioning intentions, we intend to ask all of our providers of mental health services, via regular performance reports, to account with detailed evidence (including statistical evidence) for how they are acting to achieve the seven success criteria, and for how they plan to address any identified shortcomings. We will develop these accountability frameworks jointly across the CCGs and Manchester City Council, to ensure consistency and continuity of performance management arrangements across health and social care. This will therefore build into a new framework of performance indicators, developed between ourselves as commissioners, and our service providers. We will then expect to see regular improvements, year-by-year – both in the detail and meaningfulness of the data being presented, and in the levels of performance being reported.

As commissioners, we will then intend in turn to be held accountable for demonstrating:

- How service providers are gathering and reporting data about outcomes, across the seven success criteria. This will include ensuring compatibility of reporting and data frameworks, so that we can understand and aggregated outcome data across different providers.
- How we are increasingly linking payments to providers to the outcomes which they achieve, including CQUINs and quality premiums
- How we are reshaping local services in response to the outcomes which are being achieved, including: developing improvement plans to ensure better outcomes; and moving investment to different service models, or different providers, which are achieving better outcomes

Delivery of these outcomes will require, we expect, a comprehensive range of mental health services, including (but not limited to):

- Services to treat common mental health problems in the community as early as possible
- Services to identify and treat serious mental illnesses as early as possible
- Services to manage acute and serious episodes of mental illness safely and effectively
- Services to support people to recovery, to regain and learn the skills they need after serious mental illness
- Services to assess and treat the full range of mental health problems, and which work alongside physical healthcare services when required
- Services to assess, treat and care for mentally disordered offenders
- Services for the full range of ages, from children and young people, through adults of working age, to older people

All of these services should operate within a clear stepped-care model, whereby people are seen within the least intensive service which is able to meet their needs, and only referred into more intensive services as those needs change. This should equally mean that no-one should have to use a more intensive service for want of sufficient services at a lower level of intensity.

2.3. Responding to the current needs of the health and social care economy

The above vision is very deliberately outcome-focussed, as we wish to move over time towards commissioning relationships and commissioning processes which operate primarily in this way. This outcome-focussed vision is "where we want to be" in the longer term. In the short- to medium-term, however, there are a number of more specific and early improvements which we seek to the organisation and delivery of mental health care in Manchester. Addressing these deficits, and working to develop an outcome-focussed approach, will provide us with a secure base on which to build an outcome-focussed service, and enable us to ensure a fit for purpose mental health system into the longer term.

In implementing all of the intentions set out in this section we will also ensure that:

- We draw on the best available research evidence and policy guidance
- We continue to involve service users and carers in the detail of how services develop
- We will monitor providers' performance within a suitable contractual framework
- We will continue to work with the regulators and inspectors in monitoring and improving quality in all commissioned services

Our six main short- to medium term commissioning intentions for mental health services are therefore as follows:

a) Ensuring that the acute care pathway is fit for purpose
We wish to secure acute care arrangements which ensure:

- All people (of all ages) in acute mental crisis, presenting a *serious* risk to their health or safety or that of other people, are assessed in the local area by suitably trained and experienced staff within at most four hours of referral.
- All people (of all ages) who present a *significant* risk to their health or safety or that of other people are assessed by suitably trained and experienced staff within at most 24 hours of referral
- If, following this assessment, it is decided that management without hospital admission is safe and in the patient's best interests, home treatment or another suitable alternative to admission is available until the crisis is resolved
- If, following this assessment, it is decided that hospital admission is required, a suitable local bed is available within at most four hours of the assessment
- No-one has to be admitted to a bed outside Greater Manchester, unless for a highly specialist service which is not available at all within Greater Manchester. We would expect the adoption of this principle to result in a very substantial reduction in the number of spot placements of people in acute mental health crisis into remote services
- The case mix of patients within each ward is as similar as possible, so that specialist skills can be applied to people with differing illnesses, stages of illness, or behavioural presentations – and that privacy and dignity of men and women are appropriately maintained. This consideration should not however take precedence over the others listed here i.e. we would prefer to see a rapid

local admission to the most suitable bed available at the time, rather than a long wait for exactly the right bed to become available
- People who are admitted to hospital do not need to stay there for longer than they need, for want of appropriate treatment within hospital, or suitable aftercare arrangements. This should include access to home treatment services to facilitate discharge as soon as this is a safe means of meeting the patient's needs

These standards should also apply if a person is brought to a place of safety by the police under sections 135 or 136 of the Mental Health Act.

b) Developing more formal understandings and structures around service interfaces, access, and care pathways

We wish to work with our mental health providers to ensure:

- There is a single point of access for all referrers and the public to all statutory mental health services for adults in Manchester, with sufficient knowledge of all providers' services to hold the referral until the patient reaches the most appropriate service
- There are detailed protocols in place governing transitions between services which work together regularly, to ensure that arrangements for care are handed over (or provided jointly) as efficiently and effectively as possible. For example, this is particularly important for the transition arrangements between services for children and adolescents, and services for adults; or for safe and effective arrangements for the assessment, care and treatment of mentally disordered offenders
- There are agreed care pathways for each group of patients, explaining the services which will be provided – and including versions explaining the pathways to the general public of Manchester. These care pathways will be based on the national care cluster framework, but will include additional detail to ensure that, for example, the particular needs of people with an eating disorder, or people with a learning disability are properly described and the care pathway specified

c) Agreeing the principles of risk and recovery management

Good mental health care avoids creating both unnecessary risk and unnecessary dependence on services. Whilst this will always be a matter for individual clinical judgement and patient choice, we intend to work with providers to agree principles and protocols governing the management of clinical risk – so that all parties are as clear as possible as to where boundaries lie, and so that commissioners and providers share a common understanding as to the approaches we are seeking and supporting.

d) Formalising the sharing of information with providers

Via these commissioning intentions, we wish to signal a clear expectation that providers receiving investment in their mental health services from the Manchester CCGs or the City Council will be required to work on a wholly open-book basis with us. This will mean an open willingness to share with us as commissioners all (non patient-identifiable) data which is available internally within the provider organisation, be that about outcomes, processes, staffing levels, costs, or other aspects of

performance. Implementation of the principles of the Francis report requires an unequivocal commitment from providers to working with us in this way.

In the short- to medium term, we then intend to use this information to review in detail the distribution of our investment across services, and to make such redistributions between services, in discussion with the relevant provider(s), as may be required to ensure that that distribution best meets Manchester's needs. We cannot, of course, be certain what the nature of those redistributions may be until we have access to the full range of service-line and patient-level data which we will require.

In the longer term, use of such information, alongside the outcome-focussed framework described above, will ensure that the CCGs and the Council are able to make commissioning decisions based on the fullest range of evidence.

e) Improving the integration of mental and physical health care

We intend to work with providers (both mental health and other providers) to develop a programme to improve the integration of mental and physical health care in Manchester. This will have three main elements:

- Ensuring that people with serious and enduring mental health problems have equitable access to physical health care
- Developing links between services (and possibly some targeted services) to ensure that people with both long-term health conditions and common mental health problems receive coordinated care packages. These will be community-based services, and should reduce the demand for hospital-based services (both outpatient and inpatient) for the management of comorbidities.
- Ensuring that arrangements for psychiatric liaison in our acute hospitals are at a scale and organised in a way which matches emerging good practice in this field. This will be of particular importance for older people with dementia, but will be relevant across a range of mental health problems. Arrangements of this nature should also support the management of people presenting at general hospitals with complex mental and physical co-morbidities

We intend that these changes should be possible very largely as invest-to-save initiatives, i.e. that investment in more integrated mental health services should release savings by reducing the numbers and lengths of hospital admissions, and the long-term need for higher levels of community support. (These particular savings will be in acute and general healthcare, not within mental healthcare i.e. we are envisaging an element of additional investment in mental health services in order to achieve savings and efficiencies in the wider health economy.)

f) Improving links between the statutory and voluntary sector in mental health

The voluntary sector plays a vital role in Manchester's health and social care system, often reaching into specific communities and providing peer and focussed support in ways which statutory services find difficult to match. Such organisations are essential to maintaining and improving the wellbeing of our city. We are reviewing in detail the contribution of the voluntary sector to mental health care in Manchester, and considering how best to develop links and relationships between statutory and voluntary services. This could include consideration of both the level of the individual service user, and also the overall organisational relationship – for example, the

potential for developing "prime contractor" systems with lead contractors working with a network of smaller providers within a care pathway. Our aim is to ensure that we draw on the contribution of the voluntary sector in what works well, and what can be achieved in Manchester.

3. Implementing the vision – securing the best pattern of mental health service provision for Manchester

3.1. Approach to procurement and overall system design

Section 2 above has set out our vision for the outcomes we seek from mental health services and a series of more immediate and specific commissioning intentions for the short- to medium term. In this section we set out the implications we see of this vision and these intentions, as regards the pattern of providers, and the market for mental health services in Manchester.

We think it important that we set out here how we intend to approach the idea of the local "market" for mental health services. We acknowledge in these intentions our experience that the current fragmentation of the provision of mental health services in Manchester across multiple providers has created difficulties. Whilst the quality of individual separately-contracted services has generally been good, the additional complexity of creating and maintaining effective care pathways between providers has not always worked in the interests of patients.

We therefore envisage moving towards an approach to procurement of adult mental health services which reintegrates most (but not necessarily all) healthcare services into a single system-wide contract for mental health services, to be provided either directly by a single provider, or to be subcontracted as part of a lead provider arrangement. In determining exactly which services should be reintegrated, we will consult with the organisations currently and potentially affected, and with other local stakeholders. We will also consider whether, and to what extent, any social care services might be rolled into this single contract arrangement. .

We do not envisage children's mental health services forming part of this single contract, and we will continue to procure these services via a separate contract, given the particular need to ensure effective integration of children's mental health services with other health and social care services for children. We do however need to consider how best to manage the care of 16/17 year olds.

It should be stressed that, in this section, we are not seeking to pre-empt or to constrain the ability of any individual provider (whether currently providing services in Manchester or not) to provide mental health services to the residents of Manchester. Nor are we seeking to direct any provider to seek any particular form of consortium, partnership, association, or merger with any other provider. We however think it important to set out clearly in these intentions both our overall approach to this issue, and the key factors which will guide our decision as commissioners as to the provider(s) with which we will wish to work.

3.2. Key criteria for evaluating providers

Our view is that providers who wish to maintain or develop a role in providing mental health services in Manchester will need to demonstrate how they will enable us to

meet our vision for services, and how they will deliver on our medium-term priorities. They will therefore need clearly to demonstrate how they achieve the following (either currently, or prospectively, based on realistic development plans, and/or proposed consortium arrangements).

1. An understanding of the health and social outcomes they are currently achieving for their service users, and plans for continuing improvement in those outcomes
2. Levels of patient safety comparable with high-performing mental health providers, again with convincing plans for continuing reductions in avoidable harms
3. Expertise and experience across the spectrum of care pathways required
4. Excellent feedback from both people who use services, and staff working within the service, with clear evidence that a positive staff and patient culture exists, and is being developed
5. Good relationships with referrers and with partner organisations, including both informal communications and formal interfaces
6. Expertise and experience in providing integrated health and social care services
7. An acute care system which meets all of the standards set out above, i.e.:
    a. Rapid assessment by suitably trained and experienced staff
    b. Provision of home treatment or another suitable alternative to admission wherever this is clinically safe and feasible
    c. If admission is required, this to be to a local bed, and rapidly
    d. Wards with specialist skills for particular groups of patients
8. A demonstrable openness to and enthusiasm for integrated care arrangements with acute and community general healthcare
9. Services which are responsive to the needs of complex multicultural communities, and which work closely with relevant voluntary sector organisations
10. A clear willingness to work on a fully open-book basis with commissioners
11. Costs at or below national median reference cost levels

Our responsibility as commissioners in turn is to ensure that we provide the financial resources sufficient to enable these expectations realistically to be met. Our levels of investment in mental health services are at present comfortably above the mean, when weighted for morbidity; it is our intention to maintain that level of investment in real terms. Within this financial context, therefore, we believe that all of these expectations should be realistically achievable.

However, we are not satisfied that current arrangements in our mental health system are demonstrably and sufficiently consistent with most of these expectations. Our expectation is that providers will need to think and act radically differently in developing their responses to these commissioning intentions. We are not seeking continuity-with-evolving-improvement; we are seeking modern, open, outcome-focussed and safety-focussed services from provider(s) with the scale, expertise, and relationships to enable rapid change and improvement to be delivered.

In making this assessment, we fully acknowledge that historic commissioning decisions in Manchester have contributed to this situation, in that piecemeal

procurement exercises have created an unusually fragmented service, with a greater level of complexity than we would now consider desirable.

We are therefore signalling, via these commissioning intentions, a clear determination to address these deficiencies.

4. Next steps – and the implications of these commissioning intentions

Manchester has seen a number of reports over the last ten years into mental health, mental health providers, system wide health and social care issues, performance and patient safety concerns and commissioning. These commissioning intentions have been developed as part of a clear wish to move on from this cycle, to take a firm lead as local clinical commissioners, and to bring about significant improvements in Manchester's mental health services.

Short and medium-term: action planning

Work is already underway, and an action plan has been developed, to address the short and medium-term needs of the health economy, as set out in section 2.3 above, and within the constraints of existing contracts and provider configurations. We will continue to take forward this work as much as is possible within these constraints. We are very conscious that significant service change can be disruptive and will therefore continue to do all we can to ensure that local people requiring mental health care receive high quality, safe services and have confidence in them.

In addition, we will be using the framework provided by these commissioning intentions to develop more detailed service specifications, and a financial investment plan.

Medium- to long-term: configuration implications

Discussions are also underway with all relevant organisations as to the longer-term implications of these commissioning intentions. These include all the major providers of mental health services in Manchester, the Local Area Team of NHS England, the Trust Development Authority, and Monitor.

Alongside these commissioning intentions, and subject to their approval by the boards of the three Manchester CCGs, and by Manchester City Council, we are developing (and will be regularly updating) a risk management strategy and a communication strategy to support the next steps in their implementation.

Next steps

As next steps, therefore, in taking forward the implications of these intentions, it will be necessary for the CCGs and the City Council to:

- Formally confirm support for the service and outcome framework set out in these intentions
- Take forward more detailed work on outcome-focussed service specifications and financial plans
- Continue to develop the risk register and communications plans as implementation proceeds
- Continue to maintain discussions with all relevant organisations: the major providers of mental health services in Manchester, the Local Area Team of NHS England, the Trust Development Authority, and Monitor.

We will also be developing a detailed implementation timetable for this work, following approval in principle of these commissioning intentions.

Annex 2

Manchester City Council
Draft Mental Health and Wellbeing Commissioning Intentions 2013-15
August 2013

1. Strategic Context

1.1 The work regarding the integrated commissioning of health, social care and mental wellbeing covers a broad agenda which supports Manchester's Community Strategy and the Council's priorities of promoting economic growth and reducing dependency. Supporting people to become more independent and achieve their potential will both reduce the costs of dependency and encourage citizens to access employment and skills training. In June 2013, CCGs produced, in partnership with MCC, a draft Joint Commissioning Intentions document which set out the intentions in relation to Primary and Secondary Mental Health Care. These are currently being discussed as part of a wider stakeholder engagement programme.

1.2 This report sets out Manchester City Council's (MCC) complementary commissioning intentions for mental health and wellbeing across the life course of its citizens. The approach reflects the understanding that the mental health and wellbeing of all individuals of all ages has a fundamental impact on their chances in life. However, it should also be noted that there is the intention to bring together both sets of commissioning priorities to ensure that the focus is on prevention and early intervention as well as services for people with enduring mental ill health.

1.3 The intentions have been developed in light of a number of significant changes taking place within the Mental Health sector in Manchester which are changing both the landscape and commissioner expectations as to how services will be commissioned in the future:

- The establishment of Clinical Commissioning Groups (CCGs) from April 2013 which has given GPs overall responsibility for commissioning health related mental health services.
- The recently agreed strategic outline case for the Living Longer, Living Better programme which tasks the City Council and key partners to accelerate progress on better integration of services for Manchester residents.
- The disestablishment of the mental health pooled fund arrangements in March 2013 has led to the Council now having a direct commissioning relationship with Manchester Mental Health and Social Care Trust (MH&SCT).
- From April 2013 Public Health funding and responsibilities were transferred to the City Council.
- The Council's public service reform programme, including key principles of reform such as investing in evidence based interventions, as well as the linkages to existing priority themes such as the Troubled Families programme

- An independent review of the mental health sector was commissioned, in late 2012, by the CCGs and MCC to ascertain how well services in Manchester worked. Based on those findings, a number of recommendations have been made and these have been reflected where relevant within these intentions alongside other reviews.
- A restructure of commissioning arrangements within the Council, completed in July 2013, has merged children's and adults commissioning into a single directorate.

1.4 The transfer of public health and the merging of children's and adults Commissioning structures allows the City Council to fully reassess it's mental health requirements and provision from early years and throughout life.

1.5 These services have a pivotal role in supporting individuals who are receiving health services in moving them into employment, and therefore independence, and, wherever possible, achieving their maximum potential as citizens within communities. In addition they serve an important role in supporting individuals to be, and remain, active and contributing citizens by giving opportunities for people to improve their health and wellbeing, offering education and building the resilience of the population.

1.6 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.

1.7 These commissioning intentions have been informed through customer feedback during the development of the recovery service specification, the review of supported accommodation and the evaluation of training programmes. However, there will be further engagement on these draft proposals with citizens and carers within the city.

2. In-Scope Services

2.1 While focusing on the services directly commissioned by Manchester City Council, consideration is given to all elements of the mental health landscape, particularly where there are opportunities to improve health and social care outcomes around service pathways.

2.2 Draft joint commissioning intentions are in place with Manchester's CCGs and it is our intention to maintain a contractual alignment in relation to our statutory assessment and care management functions. This will enable us to maintain the current integrated state while refreshing service specifications.

2.3 The following services are included within the commissioning intentions:

- Statutory Assessments and Care Management
- Mental Health Social Care Homes
- Mental Health Home Care

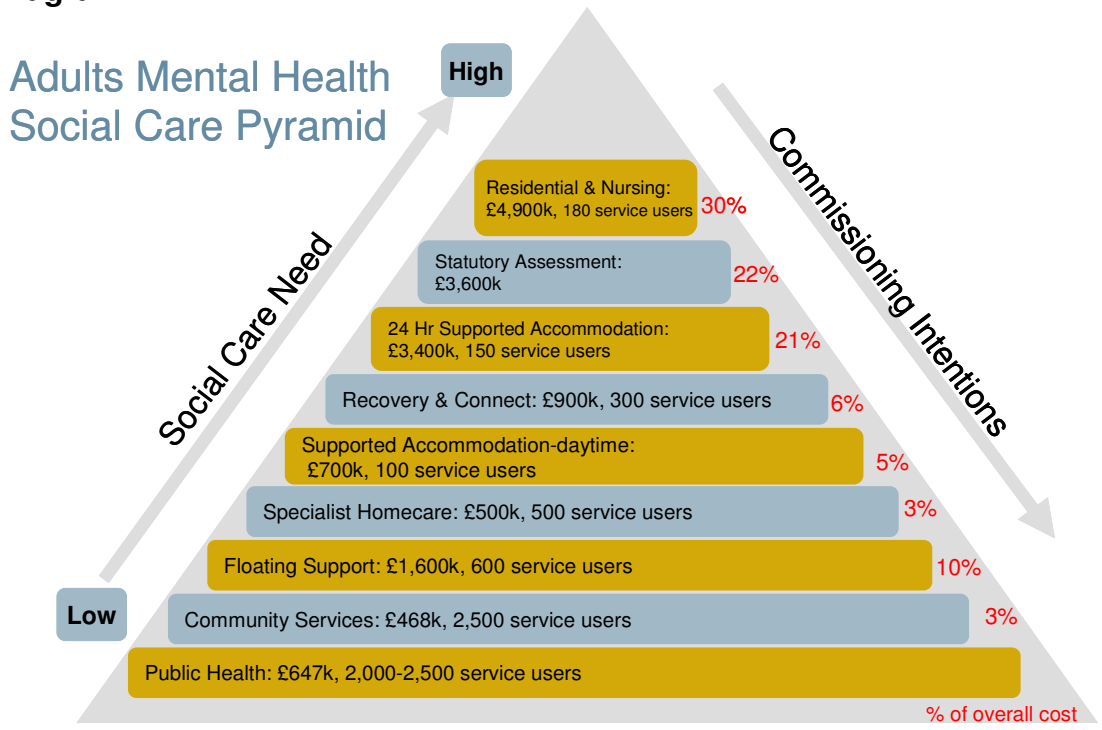
- Mental Health Supported Accommodation
- Mental Health Voluntary and Community Services (VCS) for all age groups
- Lifestyle and public health services which support mental ill health.
- Mental health services that support residents move into sustained employment

3. Current Provision

3.1 With regard to the adult population Manchester City Council currently commissions a range of services to meet the spectrum of mental health needs.

3.2 Current investment within mental health services is directed at the highest level of need. Diagram 1: illustrates and summarises the high level of investment against need and shows that of approximately 7,000 people accessing mental health services the 5% in the top level of need had 66% of the total investment. It is the intention of the Council to redirect funding, where possible, from high need accommodation based services to lower level preventative community based services. This can be achieved by supporting those at the highest level to achieve recovery from mental illness while preventing, with evidence based interventions, children, young people and others from entering more crisis based services.

Diagram1



Public mental health is a critical element of the City Council's overall mental health strategy and can support the primary prevention of mental health problems and the development of a recovery focussed agenda. Elements from public health include training in mental health issues for frontline staff, training

for residents in managing their mental health and improving the physical health of people with mental health problems as part of a recovery strategy.

4. Demographic Trends

4.1 Mental wellbeing

There has been much research and discussion about the nature of mental wellbeing in recent years including:

- the relationship to mental ill health
- how we might measure it
- the financial burden of mental ill health and low levels of wellbeing
- effective interventions to promote mental wellbeing

The scale and impact of low levels of mental wellbeing can be summarised as follows;

- Manchester has a sizable population with low levels of measured subjective mental wellbeing. As well as being associated with higher levels of mental ill health, this is also associated with poorer physical health, higher unemployment and lower levels of education. Whilst individual social and economic circumstances may determine levels of mental wellbeing, the converse is also true; that low levels of mental wellbeing are a barrier to improvements in health and economic status for individuals and communities.

- The 2009 North West Mental Wellbeing Survey is a powerful source of data due to the large sample size (18,500) and the use of face to face interviews. This shows that mental wellbeing is low for 16.8% of the NW population as compared to 23.7% of the Manchester population.

- Low mental wellbeing is not the same as mental ill health, yet the survey showed that people with low mental wellbeing are more than three times as likely to be anxious or depressed than those with higher levels of mental wellbeing. In Manchester 76.1% of the sample said they were not anxious or depressed, i.e. nearly a quarter thought they were.

The recent mental health strategy 'No health without mental health'[2] 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 disabilities3

[2] No health without mental health: a cross government outcomes strategy for people of all ages. DH. 2012

- Those who have suffered abuse and/or domestic violence
- Offenders
- Homeless people
- People with drug and alcohol problems

The reduction of stigma and inequalities in access to support and treatment are seen as key objectives in the strategy.

4.2 Mental ill health

4.2.1 The North West and in particular Manchester, has a higher than average rate of mental illness amongst its population. The National Psychiatric Morbidity Survey is regarded as the most authoritative evidence on the prevalence of mental ill-health in private households. In this survey people were asked about their experience of symptoms the week before the interview. 16.4 % of adults nationally reported symptoms significant enough to be classified as experiencing a neurotic disorder. The rate for the North West Region is highest in England at 20.3%.

4.2.2 The estimated prevalence of neurotic disorders in Manchester for the population aged 16-74 is 71,798. This figure is only an estimate and it is possible that individuals may have more than one disorder. This represents a significant level of need that affects a significant proportion of the overall population.

4.2.3 From mental health surveys it is possible to identify the characteristics associated with the prevalence of common mental health problems. They are more common in:

- Bereaved, separated or divorced people.
- Those with lower educational attainment and from Social Class 5 (V).
- People who are unemployed i.e. economically inactive.
- Tenants of local authority or Registered Providers living in urban areas and who have moved home frequently.

4.2.4 At the higher end of need there are approximately 2,100 people living in Manchester with a psychotic disorder, based on the National Psychiatric Morbidity Survey. However this may be an underestimate because of the sampling difficulties experienced by the National Survey.

4.2.5 A recent review of the epidemiology of severe mental illness[4] concludes that between 4.8 and 11.3 people per 1,000 population will have schizophrenia.

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[3] Long-term health gains: Investing in emotional and psychological wellbeing for patients with long-term conditions and medically unexplained symptoms. NHS confederation. 2012

[4] Lewis, G., Thomas, H., Cannon, M. Jones, P. (2001). The application of epidemiology to mental disorders. In Thornicroft, G. & Szmuckler,G. (eds). Textbook of Community Psychiatry. Oxford University Press.

This suggests that there will be between 1,700 and 4,000 people with these symptoms living in Manchester, although because of the socio-economic profile of the city it is more likely to be towards the upper end of this range.

4.2.6 It is also possible to estimate the incidence (i.e. the number of new cases which will arise in a population in a year). This is useful in establishing need in relation to early intervention services[5]. Extrapolating average incidences from epidemiology studies there will be between 40 and 87 new cases each year, consistent with the findings from the study of first onset psychosis in Manchester[6] which identified 90 new cases a year, 12 of which came through children's' mental health services.

4.2.7 The demographic trends of increasing need are consistent with increased demand on services. There has been an increase of new people paid for through Individual Budgets equating to a 71% increase. There is still a clear trend of increased demand particularly in higher risk and more complex cases. Table 2 summarise the total new cases in 2011-12 and 2012-13 that have been awarded an individual budget.

Mental Health IB Panel Demographics Summary - New Cases 2011-12 and 2012-13		
	New Cases 2011-12 Total	New Cases 2012-13 Total
Residential	23	79
Nursing Residential	12	20
Home Care	63	109
Day Care	10	7
Supported Accommodation	25	27
Korsakoff	17	6
Preserved Rights - Nursing	1	0
Preserved Rights - Residential	2	0
Adult Placement	0	1
Cash Individual Budget	2	17
Total	155	266

4.2.8 The current economic climate is predicted to have a continued effect on people's health and wellbeing. There are 60,815 out of work benefit claimants in Manchester of working age (May 2011), of which over half or 32,305 are claiming Incapacity Benefit (IB) or Employment Support Allowance (ESA), the two main sickness related out of work benefits (Nov 2012). In terms of IB/ESA/Severe Disablement Allowance (SDA) claims, those classified as

[5] Jablensky, A., Sartorius, N. & Emberg, G. (1992). Schizophrenia: manifestations, incidence and course in different cultures. PsychologicalMedicine 20: 1-97

[6] Drake, R., Tarrier, N. & Lewis, S. (2005). First episode psychosis in Manchester. Divisions of Psychiatry and Clinical Psychology, University of Manchester.

having mental and behavioural disorders as the primary health condition total 16,340. 50.5% of all IB/ESA/SDA claims in Manchester are therefore primarily for a mental disorder, however, anecdotal and clinical evidence is that physical ill health and unemployment are linked to mental ill health, with unemployed people twice as likely to have depression as those in work.

4.2.9 A phased programme of reassessment of claimants of Incapacity Benefit and assessment of health for any new applicants of Employment Support Allowance have been delivered on behalf of the Department of Work and Pensions (DWP) by means of a Work Capability Assessment since October 2008. Reassessment of all IB claimants is due to be completed by March 2014. There have been well publicised concerns that the Work Capability Assessment does not take into account fluctuating (mental) health conditions and that there is an absence of specialist mental health knowledge within the assessment process. Whilst large numbers of people assessed as capable of work have successfully appealed against the assessment decision, anecdotal evidence is that there are large numbers of residents with mental health conditions who have moved onto Jobseekers' Allowance or are within the Work Related Activity Group (WRAG) of ESA who are therefore expected to actively seek work or undertake pre-work activity, either with support from Jobcentre Plus or from the Work Programme. The Work Programme, which is DWP's support service for longer-term out of work benefit claimants and for those who are perceived to have more barriers to work e.g. ex-IB claimants, has been in place for two years now. To date, no ex-IB claimants or ESA WRAG claimants have moved into sustained employment through the Work Programme in Manchester. There are therefore concerns that the Work Programme is not supporting people with mental health conditions into work.

5. Evidence Base

5.1 A literature review of evidence about mental health interventions was recently carried out by the Council. 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 circumstances.

5.2 This more sustainable service delivery model is evidenced within the paper to be an effective way to assist people with mental ill health. Cognitive Behaviour Therapy and self help give people the tools to manage their mental health and break unhealthy patterns of thought and behaviour. The recovery model moves away from people being seen as passive receivers of services from professionals, to them being actively involved in their own recovery journey, enabled with the support of services.

5.3 Peer support is a key component of the recovery model and takes this further offering opportunities for service users to take an active role in helping others as well as themselves. In 2011 Repper and Carter examined the effectiveness of peer support workers[7] (PSWs) and found that the evidence suggested that PSWs can lead to a reduction in hospital admissions. However the real benefits of PSWs were in:

- Reducing social isolation and increasing social networks
- Improve resilience and self-management
- Increase empowerment, self-esteem and confidence
- Promote empathy and acceptance, and reduced stigma
- Instil a sense of hope

5.4 Social prescribing was also highlighted as a key component to improving social care outcomes for people with poor mental health. Social prescribing is a means to link people with poor mental health to sources of support and beneficial activity in the community as an alternative or complement to clinical treatments. Options will include voluntary organisation provision, community groups and activities, opportunities for improving health, creative and cultural activities, learning, volunteering and so on. There is evidence that such opportunities may;

- Strengthen psychosocial, life and coping skills for individuals
- Increase social support as a buffer against adverse life events
- Increase access to resources and services which protect mental health

5.5 A key area of prevention amongst the wider population is to build emotional resilience in communities. Emotional resilience broadly refers to the ability of individuals to cope with and recover from adversity. Examples of interventions that develop improved resilience include

- Increasing emotional literacy and resilience in children and young people (this is currently being developed in Manchester schools, so consistency in approach and language between this and other interventions is important)
- Making useful mental health information and self help techniques widely available (there are a number of courses using an educational approach available in Manchester, each with useful evidence of effectiveness, e.g. Boost, Living Life to the Full, Mindfulness, Recovery Education, Be Well Age Well).

5.6 Further to this, work and employment remain the primary means through which people connect with their communities and build their lives. Feeling you have made a contribution, as well as needing help, is central to building a positive sense of self esteem and this is at the heart of recovery.

5.7 The interrelationship between health and work is vital to the economic and social wellbeing of a local economy, particularly in cities such as Manchester.

[7] Repper J and Carter, T (2011). 'A Review of the literature on peer support in mental health services.' *Journal of Mental Health*, Vol 20 (4): pp. 392 - 411

Being out of work or in some instances never having been in work, puts individuals at increased risk of (mental) ill health. Supporting individuals back into work and assisting them to remain in work where they have long term health issues not only boosts the local economy but improves the life chances and health outcomes for individuals and their families.

5.8 The evidence shows that most people with severe mental illness want to work as research has consistently shown that between 60% and 90% of people who suffer from periods of mental ill health would like to work[8] and that diagnosis or severity of illness are not predictors of employability[9].

5.9 In a review of the evidence on whether work is good for health and well-being Waddell and Burton found a strong evidence base showing that work is generally good for physical and mental health and well-being. They also found strong evidence that worklessness is associated with poorer physical and mental health[10].

5.10 The literature review found that the most effective way to assist people back into employment for people with high level mental health needs was supported employment places. This provides on the job support from specialist job coaches or employment specialists. This is referred to as the place and train model and the most well-known is the individual placement and support (IPS). This was found to be more effective support compared with prevocational training and preparation model with this client group.

6. Current Commissioning Activity

6.1 The following are the key pieces of work already being carried out by mental health commissioners in the Council:

- The tendering of mental health care homes under a new recovery orientated specification, outcomes monitoring and pricing framework. This follows the completion of a strategic review and consultation in 2011-12. This project is now part of a wider piece of work by the Association of Greater Manchester Authorities (AGMA).
- 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.

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[8] Secker J, Grove B, Seebohm P (2006) What have we learnt about mental health and employment?, Mental Health Review, 11 (1), 8-15

[9] Grove, B. & Membrey, H. (2005) Sheep and Goats: New thinking about employability.

[10] Waddell, G and Burton, A. K. (2006) *Is Work Good for Your Health and Well-being?* Norwich: The Stationery Office

- A strategic review of Mental Health Supported Housing. There has already been a shift in culture within the Supported Housing sector from seeing supported housing as a long term solution to a more temporary stepping stone to greater independence. There has traditionally been issues with move on and access within the sector for a number of reasons. The review makes a series of recommendations to resolve the blockages found, including a 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 Better, Living Longer 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.
- Support to mitigate the impact of a wide range of welfare reforms on vulnerable residents continues to be developed and implemented.
- Building on the approach developed under the city's Troubled Families programme, key stakeholders in Manchester and GM are working with the DWP to develop a Work Programme Plus model, which will provide more intensive, integrated support for unemployed residents on ESA (many of which will present with mental ill health) into sustained work.
- In North Manchester the Council and the CCG will pilot a Fit for Work programme, to support those at risk of moving from sick pay onto ESA to stay in work through targeted early intervention.

7. Future Commissioning Intentions

7.1 The Council's approach to commissioning mental health services is based on the following principles:

- A shift in resource from reactive services to targeted earlier intervention with priority groups
- "Doing with" rather than 'doing to or for', recognising that enabling people to help themselves (where possible) is the most effective route to independence
- Investing in evidence based interventions and evaluating the impact of interventions to inform future commissioning decisions including where possible the financial/economic benefits
- Building on individual budgets to drive the personalisation of services, developing the available choice and supply of quality services
- Sequencing mental health services alongside other interventions to support residents back into sustained work, recognising that there is a growing body of evidence that securing paid employment improves mental health and wellbeing

- Using the council's leadership position to influence employment opportunities and pay and conditions that promote and protect mental health
- Working with local voluntary and community organisations to identify and address the wider complex map of underlying causes of mental ill health linked to wider determinants of poverty
- Targeting population groups recognised as being at higher risk of mental ill health, for example offenders, victims of domestic abuse troubled families and the LBGT community.
- Deploying alternative contracting mechanisms where appropriate to drive innovation and efficiency
- Link mental health services to other priority themes within the Council, for example:
    - recognising the key join up between early years and early help, such as the important role of health visitors in identifying and supporting post natal depression
    - ensuring the right mental health intervention at the right time for troubled families, particularly talking therapies, linked into a broader package of support
    - building the mental health offer alongside Dementia for frail and elderly residents as part of the Living Longer, Living Better programme

7.2 Summary-Future commissioning intentions for the next 18 to 24 months.

7.2.1 Promotion, Early Intervention and Prevention

In 2013-4 MCC will be reviewing investments in public health population based healthy lifestyle services. Public mental health is an important element of this review and can support the development of a recovery focussed agenda in line with 'No Health without Mental Health'[11] and in support of the objectives to improve mental wellbeing agreed as part of the Manchester Health and Wellbeing Strategy. It is important that we address public mental health on a population basis in order to maximise the potential to maintain good mental health in the city. This will include strategic review of those factors that are working against good mental health such as discrimination and unemployment and specific interventions to promote mental wellbeing including:

- Training for local residents in developing skills to manage their mental health and develop emotional resilience e.g. the 'Boost' programme (over 300 people engaged in 2012-3)
- Improving the availability of evidence based self help information and resources in the City
- Improving the physical health of people with mental health problems as part of their recovery

[11] No Health Without Mental Health: a cross government mental health outcomes strategy for people of all ages. DH. 2012

- Large scale training programmes to develop the skills of key frontline staff in addressing mental health issues (1038 trained in 2012-13)
- Investigating the feasibility of a city wide Recovery Education Centre.
- Further development of social prescribing in the city.
- Improving access and advice to employers on best practice approaches to workplace mental health and wellbeing
- Improving and expand the access to condition management and vocational rehabilitation to reduce loss of employment and improve pathways back to employment

Children and Young people

- Although this paper focuses on adults, MCC recognises the need to develop commissioning intentions for children and younger people. Within this schools and related services (for children and young people aged 5-18) play a fundamental role in delivering universal low level mental health and well being interventions. Nationally, more than half of adults with mental health problems were diagnosed in childhood, with less than half being treated appropriately at that time. It is therefore essential that Manchester has a robust and consistent school offer which is also strongly supported by targeted and specialist mental health services. It is our intention to explore greater integration and service delivery at a universal level to minimise mental health stigma and work towards a preventative agenda.
- We will also work with young people transitioning from children's services into adulthood and explore further development and configuration of community options to meet this level of need.

7.2.2 Employment and skills

- Look to develop through VCS provision further peer support and support networks to provide sustainable support options for people within the their own community and provide opportunities for those with lived experience to learn new skills and gain confidence.
- Improve integration of employment and skills services with mental health services to provide sequenced and appropriate support to move people back into work or training and mitigate the impacts of welfare reform.

7.2.3 Targeted and specialist

- Introduction of new contracting arrangements for all mental health statutory functions, e.g. assessment and care management Fair Access to Care Services (FACS) under an outcomes based contract.
- Research into the development of support pathways based in communities to complement statutory services and allow access for service users to move on to independence
- Linking to exemplar programmes such as Living Longer, Living Better and Troubled Families to support staff and service users to develop skills in addressing mental health issues

- Design, commission and evaluate a recovery focussed Mental Health Enablement service.
- Continue to embed the recovery model within all commissioned services in new service specifications and monitoring processes.
- Commission an accommodation brokerage team to assist with finding appropriate tenancies for people within the city.
- The implementation of the Supported Housing review with a strategic goal of reducing the demand for high level 24 hour accommodation
- Develop alternative service models for supporting people with long term mental illness, such as Shared Lives (Adult Placements)
- A whole system approach is needed across the mental health landscape - engaging with Manchester's Clinical Commissioning Groups and education providers in aligning commissioning priorities and outcomes for children and young people to ensure that services and their pathways provide seamless access to timely service delivery

8. Conclusions and Key Messages

8.1 The prevention of mental ill-health and the promotion of mental wellbeing are at the heart of our commissioning intentions. We want to equip staff, local organisations and communities to support local citizens to maintain good mental and physical health. We will build on the mental health training currently offered to staff with a focus on Living Longer, Living Better and Troubled Families.

8.2 Citizens, of all ages, with mental health problems can and do recover. This may or may not include clinical recovery but does mean, as much as individually possible, leading a fulfilling life and contributing to society and the local economy. We want mental health providers to be able to work with our citizens in a truly person centred way.

8.3 Our strategic commissioning intentions place recovery for citizens and recovery orientated practice for service providers at the heart of future mental health service delivery models. This approach and practice is unambiguous in terms of achieving customer outcomes.

8.4 The focus is on an appropriate shift in investment and strategy from the severe and enduring provision to prevention and early intervention. There will be a greater emphasis on helping citizens to gain employment through education, training and voluntary opportunities on the basis that 'good' work is good for mental health. Better integration of employment and mental health services is key to this. Therefore, services must offer opportunity for paid employment where appropriate, volunteering and meaningful activity to allow people to make a contribution to the City in which they live and feel a sense of self worth.