

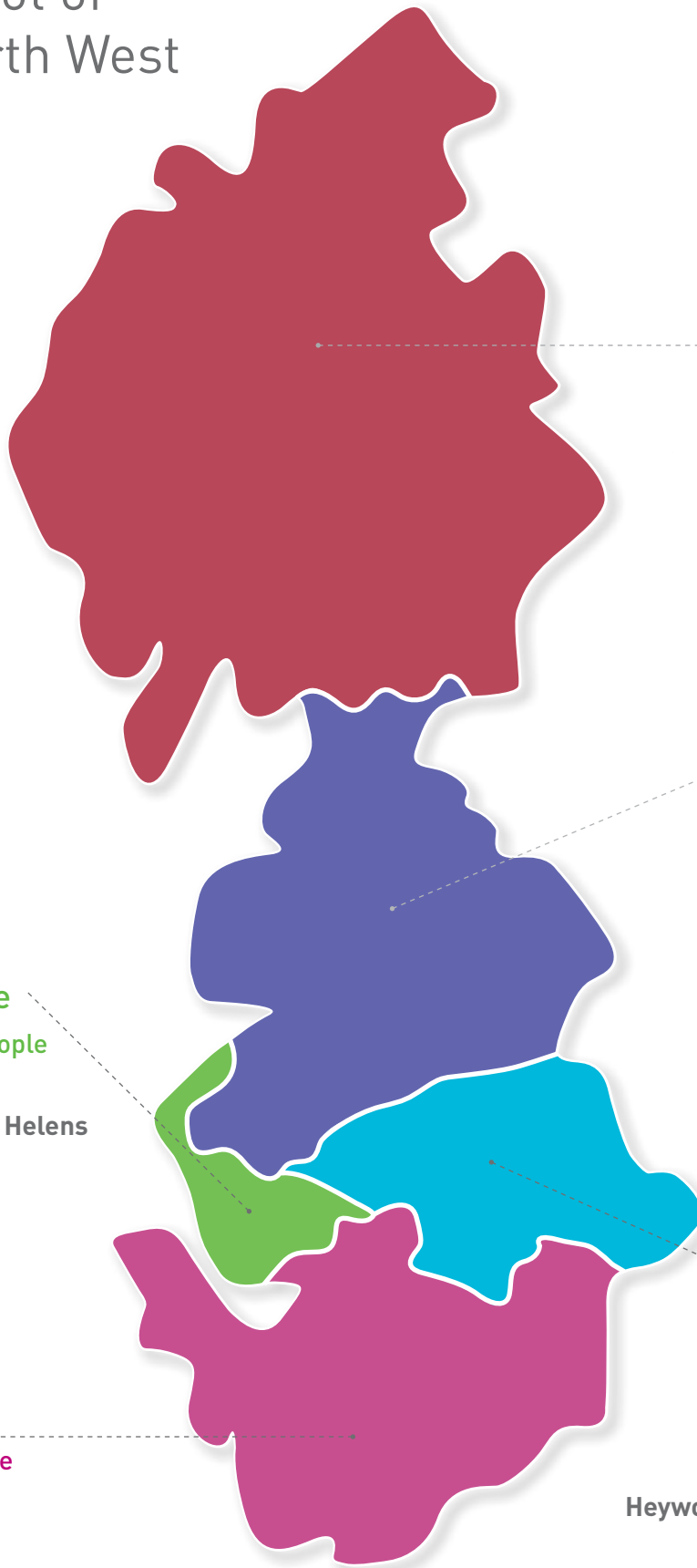


A better future in mind

**Mental health services
in the North West**

October 2008

Snapshot of the North West



Cumbria

487,000 people

Includes:
Carlisle
Penrith
Kendal

Lancashire

1.4 million people

Includes:
Blackburn with Darwen
Blackpool
Burnley
Chorley
Lancaster
Morecambe
Preston

Merseyside

1.5 million people

Includes:
Halton and St Helens
Knowsley
Liverpool
Sefton
Wirral

Cheshire

864,000 people

Includes:
Chester
Crewe
Macclesfield
Warrington

Greater Manchester

2.5 million people

Includes:
Ashton, Leigh and Wigan
Bolton
Bury
Heywood, Middleton and Rochdale
Manchester
Oldham
Salford
Stockport
Tameside and Glossop
Trafford

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An electronic version of this report with active internet links is available at:
www.northwest.nhs.uk/projects/mental_health_commission/

This webpage will also direct you to additional information, reports and references cited in this report.



A better future in mind NHS North West Commission on mental health services

This report is the culmination of a year-long piece of work sponsored by NHS North West, the region's strategic health authority (SHA), and shows its commitment to advancing mental health services.

It recognises the challenges which people with mental health problems across the North West face and the difficulties of tackling these in the NHS and other sectors. It also recognises that much progress has been made through the dedication and enthusiasm of staff and the contribution of service users, their carers and the wider community. Much of this progress has been made as a result of the 10-year National Service Framework for mental health published in 1999. As the framework now nears its end it is time to evaluate its impact and consider how best to take the agenda forward over the coming years.

Most of the money spent on mental health goes through the NHS and as such we have focused our attention there. However, we are very aware of the part played by a wide range of other organisations and have sought to reflect this in our report.

We have tried to consider the needs of all client groups in the North West. Whilst the report does not identify issues and recommendations for each one of these groups, we believe

that our recommendations will have a positive impact for them all. During our work we found no shortage of passion and commitment for improvement but despite this, some significant problems still persist. These problems predominantly relate to the wider system within which services are delivered, including the engagement of those we should be seeking to serve, choices and priorities for investment and the focus of our responses on treating illness rather than trying to avoid it.

We have looked at the way these problems have been tackled and reviewed the effectiveness of these approaches. We have made recommendations which will strengthen the system overall and be more effective in finding lasting solutions to these long-standing problems.

We have also tried to identify some of the places and projects where very different, innovative and imaginative things are happening to demonstrate what can be achieved. We have included examples of these in an electronic annexe to this report.

This report does not sit in isolation nor can it be taken forward alone. Locally and nationally, the past six months has seen the publication of other relevant reports. Healthier Horizons published by NHS North West; Vision 2015 produced

by a cross-section of bodies in England; Sir Jonathan Michael's independent inquiry into health services for people with learning disabilities and the Bradley Review and Dementia Strategy Consultation currently under way will all need to be taken forward together to find ways to improve mental health services.

We commend this report to the SHA, the NHS and social care community, the independent sector and, most importantly, people across the North West who either are, or could be, affected by mental health problems. Pursuit of our recommendations can and will make a significant contribution to ensuring that the people of the North West access better services and have better mental health for many years to come.

John Boyington
Chair

“ We have also tried to identify some of the places and projects where very different, innovative and imaginative things are happening to demonstrate what can be achieved. ”

Why have a Commission on mental health services?

Significant changes have been seen in mental health services since the introduction of the *National Service Framework for Mental Health* (DH, 1999). The SHA took a decision to review the impact of these changes in the North West and use the findings to set a new agenda for mental health.

Mental health problems are common. Nationally, one in six people has a mental health problem that requires treatment and one in four GP consultations involves a mental health component of some kind. The cost of poor mental health to the national economy has been estimated to be as high as £110 billion a year in the UK *Friedli & Parsonage* (2007) www.niamh.co.uk

Personal costs can also be high with people who experience a prolonged mental health problem or have a severe and enduring mental illness, often living in poverty and experiencing a lower quality of life.

According to national statistics the North West of England is the second most socially deprived area of the country. Data available on the North West Public Health Observatory website www.apho.org.uk show that on indices such as life expectancy, children in poverty

and healthy eating, the North West does consistently badly. It is not surprising, given this relative deprivation, that the psychological well-being of the people of the North West is also substantially below the national average. Relative to the other regions of England the North West has:

- the second-highest rate of people on incapacity benefit for mental or behavioural disorders
- the second-highest suicide rates for men and women under the age of 75
- the third-highest rate of drug misuse.

The high use of health services is also a reflection on the poor psychological well-being of the population www.nepho.org.uk (Figure 1).

Factors that can increase the risk of mental health problems in the North West include a higher-than-average unemployment rate and one of the lowest employment rates amongst people once they have a mental health problem.

The recent review of the health of Britain's working age population (Black, 2008) www.workingforhealth.gov.uk reported that initiatives to help people back to work, while successful overall, have had a limited effect for those whose main health condition is

mental illness.

Such a high level of population need requires investment, efficiency, innovation and quality from those who commission and provide mental health care and services to prevent illness and promote mental well-being. But is this the case in the North West and what could be done not only to meet these challenges but to make the North West's mental health and mental health services something to be proud of?

Figure 1

- The North West has the **highest level of hospital admissions for depression and anxiety** at 55 per cent and 29 per cent above the national average respectively
- The region's rate of **hospital admission for schizophrenia** is also the **highest nationally** – 39 per cent higher than the national average
- It has a hospital admission rate for **self-harm 26 per cent higher than the average for England**
- It has the highest rate of hospital stays for **alcohol-related problems**

What the Commission did

The Commission was set up in September 2007 to review mental health services in the region and make recommendations that would ensure that world-class services are being consistently provided for the people of the North West. Further information on Commission members is available at www.northwest.nhs.uk/projects/mental_health_commission/Biographies.html

The Commission was supported by a **reference group** made up of 43 regional and national stakeholders, at least a quarter of whom were service users or carers. This group also aimed to be representative of the geography of the region and to reflect an ethnic and gender mix.

We took evidence from a wide range of stakeholders, especially

service users, carers, family members and the general public. We also received evidence from commissioners, service providers, voluntary and private sector organisations, social care and other local authority service providers, criminal justice professionals, professional bodies and trade unions.

We held meetings across the North West to hear stakeholders' views on current services, their strengths and short-comings.

Particular attention was paid to reaching people whose views are often not gathered, including children, older people, people with a learning disability, minority ethnic groups and people who have been on probation or in prison.

The University of Central Lancashire conducted a specific engagement exercise on our

behalf with 35 groups of stakeholders from across the region whose voices often go unheard.

We studied information collected on services including reports of bodies such as the Healthcare Commission, the Mental Health Act Commission, the Commission for Social Care Inspection and HM Inspectors of Prisons and Probation.

We used information and data from existing reports written about mental health services in the North West over the past five years including the enquiries into homicides committed by patients in the care of mental health services.

We thought about our terminology and agreed to use the terms in **Figure 2** for the remainder of the report.

The Commission team

(left to right):

John Boyington, CBE
(Chair)

Joanne Nightingale
(Project support officer)

Professor Mark Gabbay
(Commission member)

Professor Max Marshall
(Commission member)

Colin McKinless
(Commission member)

Professor Jennie Popay
(Commission member)

Julie Cullen
(Programme director)

Terry Lewis
(Deputy chair)





Some of the consultation events held by the Commission

Figure 2

The terms we have used

The stigma attached to mental illness has encouraged the use of the term mental health to describe treatment and support services for people with mental illness. This contributes to confusion about the concept of mental health as well as mental illness (WHO, 2004). In this report we have used the following definitions:

- **Well-being** – to describe a positive state of mental and physical health
- **Mental health problem** – to describe a range of experiences which cause significant and sometimes prolonged distress for people. The majority of these problems are not diagnosed as mental illness. They may develop into mental illness, or similar to personality disorder, present life-long difficulties for the people involved
- **Mental illness** – to describe conditions with clear symptoms that lead to a formal diagnosis
- **Severe and enduring mental illness** – to describe an illness which is likely to be serious long-lasting and relapsing
- **Mental health services** – to describe primary, secondary and tertiary health care services focusing on prevention, diagnosis, treatment and care in relation to mental health problems or illness

We also looked at high-quality services in the North West and elsewhere, to get a sense of the best practice to which the region should aspire. We were fortunate to visit a number of services which were operating innovatively and we have produced an electronic annex to this report which gives further details of all these **initiatives**. Our website also contains a list of people who we met, those who **provided evidence** and also a list of **additional information** we reviewed at www.northwest.nhs.uk/projects/mental_health_commission

What did we find?

We found evidence of progress and innovation across the North West and saw examples of excellent care and support being provided by passionate and enthusiastic professionals in the health and social care sector, independent sector, not-for-profit organisations and lay people. We found a consensus about what people thought were the characteristics of an effective system and identified many people, and some organisations, within the North West, committed to achieving this. Such a system should:

- be comprehensive and inclusive, promoting the principles of fairness, respect, equity, dignity and autonomy for service users, carers and staff
- recognise and address the fact that some people have unequal

access to services because of their social, economic or cultural circumstances; and that these inequalities may cause higher risk of mental illness or make them less likely to have positive mental health

- acknowledge the benefit to all of positive mental health, the opportunity for some of preventing mental illness and the focus on recovery for those who are experiencing mental illness
- see the experience of service users and carers as at least the equal of all other measures of success, and recognise that the best results for service users and carers come from positive relationships that fully engage them in all levels of decision-making
- acknowledge that non-statutory services, including those led by service users, are equal to those of the statutory sector and encourage collaboration between the two.

As well as this consensus, we also found evidence of some significant and long-standing problems which have been resistant to change and are a key focus of this report.

These problems are not unique to the North West, nor do they persist through lack of efforts to address them. They are complex problems, which need key mechanisms to be working well and working together to resolve them. Too often approaches in the past have been partial or short-term and solutions have failed to stick.

Significant long-standing problems

Patchy availability of services

Many of the service users and carers whom we talked to described difficulties obtaining services such as **long-term community support, crisis care and psychological support and treatment**.

GPs also told us of the difficulties they experienced in getting help for some of their patients, especially those with **mild to moderate mental illness**. Some services are not available in some parts of the region because of local decisions about resources.

The availability of **appropriate services to people in a variety of minority groups** was raised frequently and the problems with service **availability for those in the criminal justice system** are well documented. Often even when services were available, they were not the ones that people felt they needed.

Access to services

People described many difficulties in accessing services. This was a particular problem for groups with different needs such as **those with a learning disability or black and minority ethnic groups**. Access problems were often **caused by a lack of information** about available services, **the siting of services and a lack of cultural appropriateness**. Services to people arguably most in need are often not easy to access.

In our survey of **crisis intervention services** we found that almost a third of calls were not answered personally but diverted to an answering machine. (**Figure 3**).

Quality

Despite some perceived improvements in recent years many service users and carers we spoke to were **unhappy with the quality of the care** they had received. These concerns were confirmed by a review of Healthcare Commission reports carried out for us that highlighted variations in service quality (www.northwest.nhs.uk/projects/mental_health_commission). Across the North West, **relationships between professionals and service users and carers were often described as poor** with the physical environment and 'hotel' aspects of care often falling short of expectations.

We received a lot of feedback from service users, carers and staff about **poor facilities and services for people who were most acutely ill**. Many of these described acute wards as frightening places (**Figure 4**) where they often felt they had little access to support or therapeutic activity and where disturbed behaviour was common. This is known to be a particular issue in the North West for young people (**Figure 5**).

Figure 3

Crisis Resolution Home Treatment Teams (CRHTs)

All crisis teams said that the telephone was their main point of access. Our regional survey conducted on two occasions during office hours showed that only 71 per cent and 67 per cent of calls were answered on the first attempt.

www.northwest.nhs.uk/projects/mental_health_commission

Figure 4

Acute inpatient mental health wards

The 2006/2007 National Audit of Violence pointed to an increase in the frequency and severity of incidents. On acute wards for adults of working age:

- 61 per cent of nurses and 43 per cent of patients had felt upset or distressed
- 73 per cent of nurses and 31 per cent of patients had been threatened or made to feel unsafe
- 45 per cent of nurses and 15 per cent of patients had been physically assaulted (www.healthcarecommission.org.uk)

Figure 5

Young people admitted to acute wards

The North West of England has by far the highest number of occupied bed days of children aged under 16 and young people aged 16 and 17, and accounts for almost a quarter of national total occupied bed days for this age group.

Survey of adult psychiatric bed utilisation in the North West. McDougal & Bodley-Scott (2008)

Figure 7

Positive mental health

Professor Corey Keyes from the USA presented evidence to the commission about his work on mental health and 'flourishing'. Keyes has developed tools to measure mental health as opposed to the absence of mental illness and asserts that the two are separate things. He describes people with good mental health as 'flourishing' and those whose mental health is poor as 'languishing'. He has produced statistics that demonstrate that young people whose mental health is poor (languishing) are more likely to develop mental illness. He has also produced evidence that those with poor mental health are much more likely to suffer from poor physical health and are likely to take longer to recover.

Friedli & Parsonage (2007)
www.niamh.co.uk

Figure 8

Levels of prevention

- **Primary prevention** – aims to improve the mental health of communities so that people do not become ill
- **Secondary prevention** – aims to identify people who are developing early signs of mental illness so that more serious illness can be prevented
- **Tertiary prevention** – aims to prevent people who have become ill from relapsing, or helps them to recover

Lack of investment in prevention

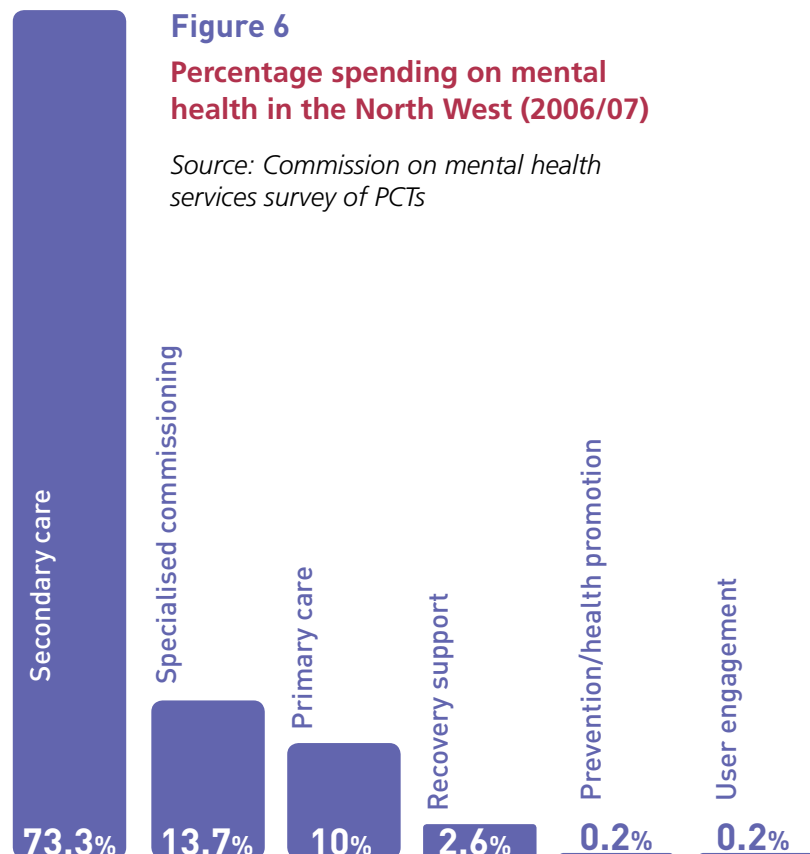
Most of the money in the North West is spent on secondary mental health services to help people who have become ill to get better (Figure 6).

Relatively little (10 per cent) is spent on primary care services, which treat most of those with a mild to moderate mental illness and manages undiagnosed mental health problems (Figure 7).

Even less (0.2 per cent) is spent on helping people to stay mentally well or to prevent people becoming mentally ill.

Helping those who become ill to achieve a full recovery and stay well remains under resourced (2.6 per cent) (Figure 8).

NHS resources need to be more effectively applied to supporting and complementing those deployed by local government and other bodies in relation to this agenda, where there are significant personal and economic benefits to be achieved (Figure 9).



Significant long-standing problems

Staff attitudes and working practices

As we have pointed out, most of the NHS budget is spent on clinical services. A medical approach is at the heart of the NHS and in the North West, as elsewhere, medical and other health professional education has a significant clinical focus.

Whilst good clinical services are essential to effective treatment, they alone cannot enable people to achieve a full recovery from mental illness, reduce the likelihood of a recurrence or prevent the onset of illness.

The way in which most professionals are trained and their values and attitudes framed too often contributes to a **mismatch between what people tell us they need, or prefer, and the services they are offered.**

A strengths-based approach to recovery (**Figure 10**) is widely acknowledged as beneficial to those who have been, or are, ill but it is not the predominant model of service offered.

In their work for us, the University of Central Lancashire (www.northwest.nhs.uk/projects/mental_health_commission) identified a problem they defined as 'professional stigma'.

Health professionals were felt to be as likely as other people to stigmatise people because of their mental health status, their group membership, culture or difference.

Professionals therefore often reflect the prejudices of wider society but this can have a greater consequence because of their role in supporting people.

Figure 9

Investing in prevention for families

Children of mothers with perinatal depression are more vulnerable to developing mental health problems and have a higher rate of referral to children's mental health services. *Murray (2001), Hay et al (2001).*

Children of depressed parents are two to three times more likely to present with childhood anxiety, disruption and depressive conditions.

Weissman et al (2006).

"Although associated with very severe disturbance, early onset puerperal psychosis and severe depressive illness are very responsive to treatment..."

Royal College of Psychiatrists (2000).

Figure 10

Principles of the strengths-based approach to recovery

- The focus of the helping process is upon the service user's strengths, interests, abilities and capabilities, not on deficits, weaknesses or problems
- All service users have the capacity to learn, grow and change
- The service user-practitioner relationship becomes a primary and essential partnership
- The service user is viewed as the director of the helping process
- Continuity and acceptance are essential foundations for promoting recovery
- The helping process takes on an outreach perspective
- The local neighbourhood is viewed as a resource rather than as an obstacle. Natural neighbourhood resources should be considered before segregated mental health services

www.practicebasedevidence.com/files/OpenMind-StrengthsBasedPractise.pdf

How have we been trying to address these long-standing problems?

These problems are already well recognised by service users, carers, professionals and organisations, and a number of mechanisms are in place to try to improve mental health services and make them more responsive to people's needs.

The mechanisms which we believe are critical to tackling the long-standing problems identified earlier are:



We have reviewed how well these mechanisms have been working in the North West, and considered how they might be made to work more effectively.

“We believe that the true potential for the long-term transformation of health in the North West lies in creating an NHS that is driven by citizens who know that their views and decisions count and who are enabled to play their part in managing their own health and well-being.”

Healthier Horizons for the North West (2008)

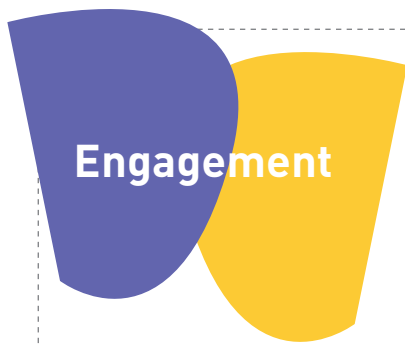
Engagement of service users, carers and the public

There is a well-established and formal commitment that service users, carers and the general public should play a central role in the design and delivery of mental health services. The recent report on the NHS in the North West *Healthier Horizons for the North West* highlighted this as key to the improvement of services. Some PCTs have developed service user and carer reference groups (**Figure 11**) and we have also seen some very positive examples of the engagement of service users and carers in treatment and care planning (**Figure 12**).

Figure 11

The Patients' Council: Take it to the top

The Patients' Council for mental health is a service-user-led organisation funded by Bolton PCT, which facilitates the involvement of service users in every aspect of mental health. It promotes a positive image of mental health and runs a range of activities to enable Bolton people to lead long and healthy lives. The Patients' Council initiated 'Take it to the top' so that anyone wishing to raise issues on mental health could do so in a monthly public forum.



Engagement



“I didn’t feel welcome when I went to hospital. It seemed as if I was a nuisance”

Service user who accesses acute hospital services

“People listen very politely, but nothing ever changes”

Service user representative talking about formal consultation

Figure 12

The Salford early intervention team

The early intervention team works in partnership with service users, their families and friends and seeks to ensure that the service user is at the centre of care and service delivery. The focus is on helping the service user to make sense of their experiences and to identify strengths, needs and areas of difficulty, as well as working towards future hopes and aspirations. The team works with a recovery-orientated philosophy, which means that as well as focusing on improving symptoms and social functioning they support the person to develop a life that feels meaningful and satisfying.

Figure 13

North West region mental health Foundation Trusts

- Cheshire and Wirral Partnership NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Greater Manchester West Mental Health NHS Foundation Trust
- Lancashire Care NHS Foundation Trust
- Pennine Care NHS Foundation Trust

The new Local Involvement Networks (LINks) are intended to give citizens a stronger voice in the health and social care services in their area. There are also new opportunities for service users/carers and public engagement through membership of Foundation Trusts (FTs).

NHS provider organisations which achieve FT status have more freedom from central control and as a consequence can lead the way in greater local engagement. These trusts have the potential to establish stronger connections between local services and people living in the communities they serve, who are able to become members of the FT and take a role in its governance. More than half of the mental health trusts in the North West region are now FTs.

In these five FTs (**Figure 13**) about 42,800 members of the public (including service users, carers and employees) are now members. These members could be a powerful force promoting the public accountability of FTs and increasing the likelihood that services will more accurately reflect the needs and expectations of local people, and be more effective in engaging service users and carers in the design and delivery of their care pathways.

However, we have consistently been told by many people that, despite commitments in national and local policy and these formal mechanisms for engagement, service users and carers too often feel ‘done-to’ rather than ‘engaged with’. This applies equally to the planning and delivery of services at individual and population level.

A recent review of research evidence undertaken for the National Institute for Health and Clinical Excellence (NICE) was subsequently used to inform the production of NICE guidance on engagement. It identified recurring organisational, professional and managerial barriers to effective engagement of lay people in health decision-making. These barriers stem from:

- unequal power relationships
- communication and knowledge
- the practices of engagement
- the costs of engagement for lay people
- professional and organisational culture and attitudes
- community resistance to engagement
- political imperatives including national demands for policy ‘quick wins’.

www.nice.org.uk/PH009

How can we make the voice of service users, carers and the public more powerful?

Commissioners and providers of services in the North West need to recommit themselves to giving service user, carer and public engagement the high status and influence that it requires if we are to improve service experience and outcomes. This will mean major changes in organisational and professional cultures and ways of working. It also needs greater financial and other support. The evidence about common barriers to engagement is known. What is needed is action to overcome them.

This will require commissioners and providers to work in different ways with service users, carers and the public – recognising that they are informed stakeholders who expect to be seen as an equal and authoritative presence. Particular attention should be given to the effective engagement of minority groups. Organisations and professionals need to be held to account for showing the impact that engagement has had. There also needs to be a greater recognition of the need to implement more paid roles for service users and carers.

The Liverpool Mental Health Consortium (Figure 14) is a positive example of service user, carer and community engagement and of a structure that seeks to support service users and carers to make an informed and authoritative

contribution wherever it is needed. The NHS and wider systems need to build on such examples to significantly improve the engagement of service users, carers and the public.

RECOMMENDATION 1

We recommend the strategic health authority uses its leadership and influence to create a cross-agency programme to support and scrutinise significant performance improvements in service user, carer and public engagement in mental health. This should directly address the known organisational, managerial, professional and cultural barriers to effective engagement.

The goals for this would be to improve organisational performance and its measurement, focused on service user, carer and public engagement.

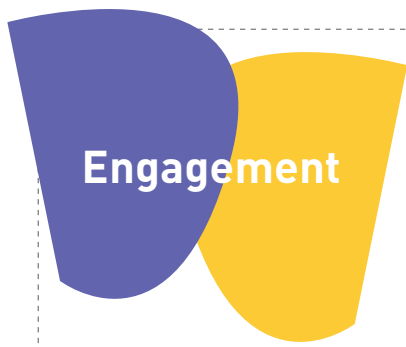
The programme in **Recommendation 1** will require financial resources and would need to be supported by a range of agencies as well as NHS North West. It should be shaped and developed through close involvement with those with experience of using, or caring for those who use, mental health services.

The focus should be on the means of promoting better engagement in decision making about the design, commissioning, delivery, evaluation and development of services.

Figure 14

Liverpool Mental Health Consortium (LMHC)

LMHC is a service-user-led membership organisation for stakeholders that includes statutory authorities, providers, voluntary sector organisations, individuals and groups who experience mental distress. It promotes partnership working based on the experiences of people who use services and operates through managed networks embracing the principles of community development and participation. It provides a structure for stakeholders' views, experiences and aspirations to be influential in formal, joint-planning systems and to feed back developments to its community members.



Engagement

We see a number of ways by which this programme could enhance the role and status of engagement in the design and evaluation of services:

Figure 15

Mental Health Centre of Denver recovery measures

The Mental Health Centre of Denver (MHCD) is a mainstream, not-for-profit, community mental health care organisation. It provides a strengths-based, recovery-focused service to 6,500 people living in the Denver metropolitan area. Researchers at MHCD have collaborated with service users to develop a number of well-validated recovery measures. For example, the Recovery Markers Inventory is completed every two months by clinicians and charts progress across eight dimensions from symptom interference to housing, employment and education.

A similar measure is completed by service users and includes symptom interference, active/growth orientation, hope, safety and social networks.

The success rates of clinicians and clinical teams are assessed by these measures and are used to inform initiatives to improve clinical quality.

www.mhcd.org

- supporting the development of incentives which value the experience of service users and carers including extending the incentive-based quality improvement scheme 'Advancing Quality' to mental health, to include measures of recovery and an extension of these principles into social care (see page 17 and **Figure 26** on page 18)
- supporting and developing better user-centred quality measures such as those developed and introduced into the Mental Health Centre of Denver in the USA to support their approach to a strengths-based model for recovery (**Figure 15**)
- supporting and developing outcome measures that directly measure the service user and carer experience, perhaps using 'User Controlled Evaluation' (**Figure 16**) and mechanisms being developed by 'Patient Opinion' (**Figure 17**)
- developing a service user kitemark with which to accredit services and organisations that are truly user-focused, perhaps modelled on lines similar to Investors in People or the Charter Mark schemes
- supporting the development and implementation of *Refocusing of the Care Programme Approach* (DH, 2008) which pays attention to a person's strengths, achievements and aspirations and incorporates the use of advanced decisions and statements

Figure 16

User Controlled Evaluation (UCE)

This has been developed in the North West by service users and professionals to gather feedback from service users on the service they have received. Service users are involved from start to finish – having designed the questionnaire, been trained to interview other service users and to interpret and produce the findings. While UCE has been well received, in many areas funding has not been available to introduce it as a part of the routine evaluation of services.

www.northwest.nhs.uk/projects/mental_health_commission

Figure 17

Patient Opinion

Patient Opinion is a not-for-profit social enterprise, which uses its national website to hear about patients', service users' and carers' experiences. Patients, service users and carers generate content by sharing their stories on the site and by rating the service they have received. Anyone can then view this feedback to find out what people thought about a particular department, ward, service or procedure. Mental health trusts and other organisations are encouraged to respond to this feedback – be it positive or negative – on the website creating a radical new way to have a dialogue and improve services and care.

www.patientopinion.org.uk

Figure 18

The youth consumer participation model

This is a user-developed enterprise from New Zealand which promotes informed representation and influence at all levels of engagement from service users. The organisation identifies, trains and develops service users for the roles they undertake, and makes sure that they are kept abreast of service and policy developments, thus ensuring that the advisor's contribution is equal to that of any other stakeholder.

www.werrycentre.org.nz

Figure 19

Cumbria mental health group

Set up as a user and carer-owned organisation. The objectives are:

- provide effective communication to enable people to participate in decisions about design and implementation of the whole range of services to help communities' mental well-being
- provide access to non threatening, safe and relaxed local forums to enable them to debate and understand issues
- provide those who wish to be more actively involved with support and training to do so. To give information about national and local policies and successful services elsewhere
- actively encourage people to take part in wider public forums to promote the inclusion of people with mental health problems
- promote service user and carer strategies while providing a forum in which commissioners and providers can test ideas, issues and solutions.

www.scmhforum.org.uk

- supporting effective implementation and evaluation of the personalisation agenda
- supporting the development and implementation of integrated community-centred commissioning models such as 'Connected Care' run by Turning Point and described later in the report (see page 20 and **Figure 28** on page 21).

Ensuring effective performance across the system is only part of the solution. Although there are examples of effective engagement across the region, the means, mechanisms and resources for enabling service user, carer and public engagement also need to be developed.

RECOMMENDATION 2

We recommend that the strategic health authority uses its leadership and influence to support the North West NHS and other partners to establish a user and carer engagement development initiative. This should enable service users, carers and communities to participate effectively as equal partners in the design, delivery and evaluation of services.

Like **Recommendation 1**, this initiative will require financial resources and needs to be supported by a range of agencies as well as NHS North West.

It must be shaped and developed in close collaboration with those who have experience of using, or caring for those who use, mental health services. It should build on the experience and successes of existing service user organisations and groups. We believe that it should as a minimum:

- secure opportunities to develop knowledge, skills and competencies
- support the development of means by which service user and carers can effectively engage with and represent their constituents
- support shared learning and collaborative working across the North West amongst service users, carers and the public, to increase their involvement at all levels, including as providers of user-run services and working with mental health users groups, LINKs, FT members and governors. See the youth consumer participation model (**Figure 18**) and the Cumbria mental health group (**Figure 19**).

Commissioning

Commissioning

In 1990, the landscape of the NHS was changed when commissioning (deciding what services should be provided and by whom) was separated from the organisations that deliver services (providers). Since then there have been considerable attempts to organise commissioning so as to maximise its contribution to securing high-quality health and social care services.

In 2001, the Department of Health (DH) document *Shifting the Balance of Power* set out how most of the responsibility for commissioning health services in England would move from the then 100-plus health authorities to 300 newly-created PCTs. This increase in commissioners placed an enormous strain on commissioning expertise in mental health at a critical time when the *National Service Framework for Mental Health* was in the early stages of implementation.

In 2005, *Commissioning a Patient Led NHS* was published by the DH to further strengthen commissioning. Many of the smaller PCTs would merge to form larger organisations with clearer commissioning responsibilities. The North West currently has 24 PCTs.

Alongside this, a system of practice-based commissioning was introduced, which involved GPs more directly in planning and purchasing local healthcare. In 2007, the processes for commissioning were further

developed by the DH publications *World Class Commissioning* (Figure 20) and the *Framework for Procuring External Support for Commissioners (FESC)* (Figure 21).

Over the past decade, legislation, policy and guidance has encouraged more integrated commissioning models between the NHS and social care. Despite some innovative examples, this process has been patchy and inconsistent. During this time, integrated or partnership arrangements have also developed on the broader health improvement and well-being front, through the mechanisms of Local Strategic Partnerships (LSPs) (Figure 22) and Local Area Agreements (LAAs) (Figure 23).

This review found that there are still major weaknesses in the commissioning system on which earlier changes have struggled to have sufficient impact. This has resulted in many mental health service users and carers not seeing the full intended benefits of the reforms. The absence of an agreed payment system for NHS services, for example, has delayed the implementation of choice between providers for service users.

Many of the stakeholders we spoke to, including those working as mental health commissioners, lacked confidence in the mental health commissioning process and in many PCTs it was described as marginalised, fragmented and lacking senior leadership.

“World-class commissioners are central to a self-improving NHS.”

Figure 20

World Class Commissioning (WCC)

WCC sets out a vision for a long-term strategic approach to developing commissioning; an assurance system to performance manage commissioning by the PCTs; a description of the functions and competencies required of commissioners and a programme for support and development.

WCC competencies

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

Figure 21

Framework for Procuring External Support of Commissioning (FESC)

FESC provides the opportunity for PCTs to partner independent providers, who can undertake aspects of the commissioning function, whilst remaining accountable to the PCT board throughout. Contractual arrangements are robust and payment models are designed to incentivise providers to deliver to the required value.

Figure 22

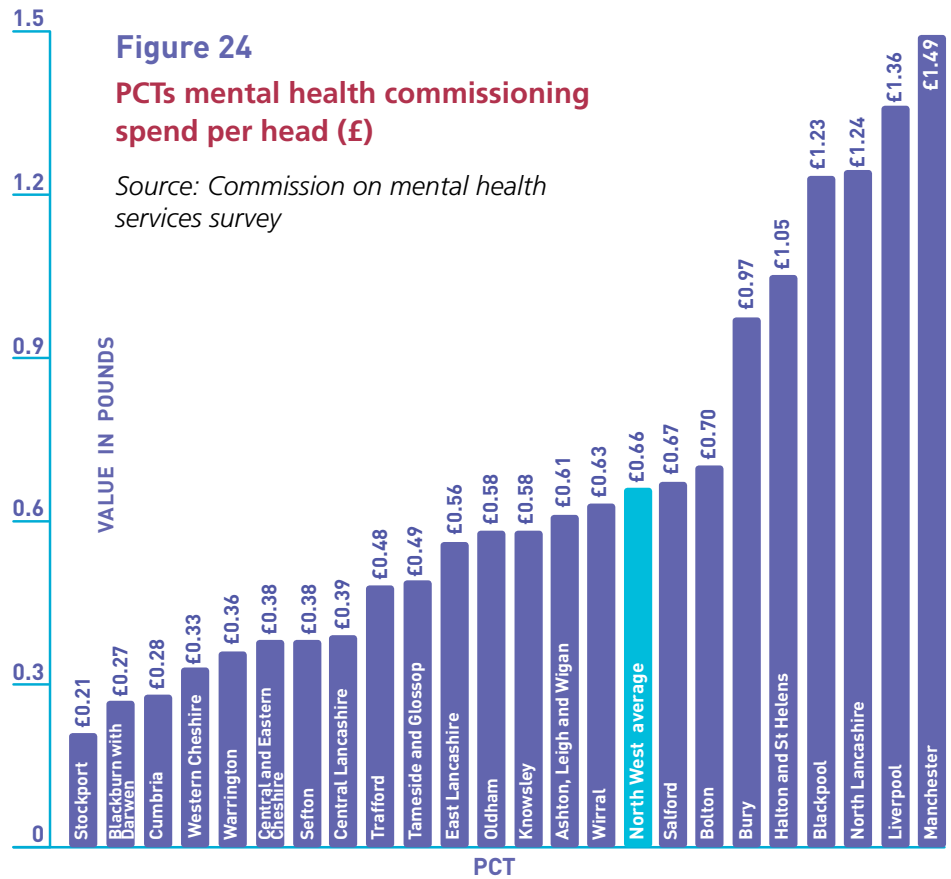
Local Strategic Partnerships (LSPs)

The community leadership role of local government (working with a range of local partners) provides, amongst other key local priorities, the opportunity to focus on the health and well-being of the local community, helping people to stay mentally well and preventing people from becoming mentally ill.

Figure 23

Local Area Agreements (LAAs)

One of the LAAs' main roles is to provide a formal mechanism for partners to agree local health and well-being priorities, pooled budgets and joint measures or targets where appropriate. The effectiveness of LSPs and LAAs is monitored through the Comprehensive Area Agreement (CAA), which also appraises the performance of partners in delivering according to local community priorities.



We found great variation in the amount being spent on the process of commissioning mental health services with some PCTs spending up to eight times as much as others (Figure 24). We have already described a major focus of resources into specialist services, with only 10 per cent on primary care and even less on prevention or well-being.

Most mental health services continue to be commissioned through simple contracts with limited detail, with the focus generally on what goes into services (inputs) rather than what is achieved (outcomes). This approach generally fails to provide incentives for people to improve services or to achieve outcomes which service users value.

Payment by Results (PbR) is a more sophisticated mechanism used in the commissioning of some health services for physical illness (Figure 25). The development of PbR in mental health has lagged far behind that in other areas.

In future, the effectiveness of treatment and the quality of the patient experience will become key incentives to payments under PbR.

To further develop quality incentives the North West is introducing a mechanism called 'Advancing Quality' (Figure 26). To date there has been no development of this mechanism in mental health but we believe this should be addressed as soon as possible.

Figure 25

Payment by Results (PbR)

is a mechanism to promote choice by patients about where their care and treatment is received. Providers are paid a standard rate for each episode of treatment – so the more patients they attract the more they are paid.

www.dh.gov.uk

Commissioning

Recently there has been more of a focus on prevention and promotion of positive mental health as a part of the measures or targets included in LAAs. These include, for example, measuring the number of people with mental health problems returning to paid work, and could be extended to include those pursuing education, leisure and volunteering, as ways of building purpose into their lives. However, as there is no requirement to include mental health measures or targets in LAAs, the benefit they deliver is not consistent across the North West.

We know that setting targets has contributed to improvements especially in non-mental health services, as, for instance, with waiting times for hospital operations and other procedures.

Most targets in mental health relate to measurements of the inputs not the outcomes. This is clear in crisis resolution and home treatment teams, where targets relate to the number of teams in place and the number of patients seen but not to the effectiveness of the intervention or user satisfaction.

We believe that the implementation of policy on WCC will bring about improvements but we do not see how this alone will address the issues of service marginalisation and lack of senior leadership, which have been frequently highlighted to us. We also acknowledge some of the

benefits which will result from wider implementation of practice-based commissioning. This may be especially true in services for those with mild to moderate mental illness and in helping to drive innovation and flexibility centred on the user or carer experience.

The data presented earlier in **Figure 6**, on page 9, shows that all PCTs need to review the pattern of their investment across well-being, prevention and treatment. The variance in investment demonstrated in **Figure 24** clearly indicates that further investment in the commissioning process is warranted in a number of PCTs. However, we believe that the impact of such an increase would not be maximised if it simply spread more thinly the current limited expertise in mental health commissioning.

Even if PCTs increase their investment in the commissioning process to improve their capacity, competence and capability, we believe that it will be difficult to find sufficient senior and experienced people to achieve this across 24 organisations.

How can we strengthen commissioning to deliver more change?

There is a widely-held view that commissioning for mental health needs to improve significantly if we are to maximise the benefits of this pivotal lever for change.

Changes to improve commissioning need to impact in a number of ways:

- build capacity to deliver the WCC competencies
- develop more integrated commissioning
- develop more sophisticated means of contracting to promote greater effectiveness and positive user experience.

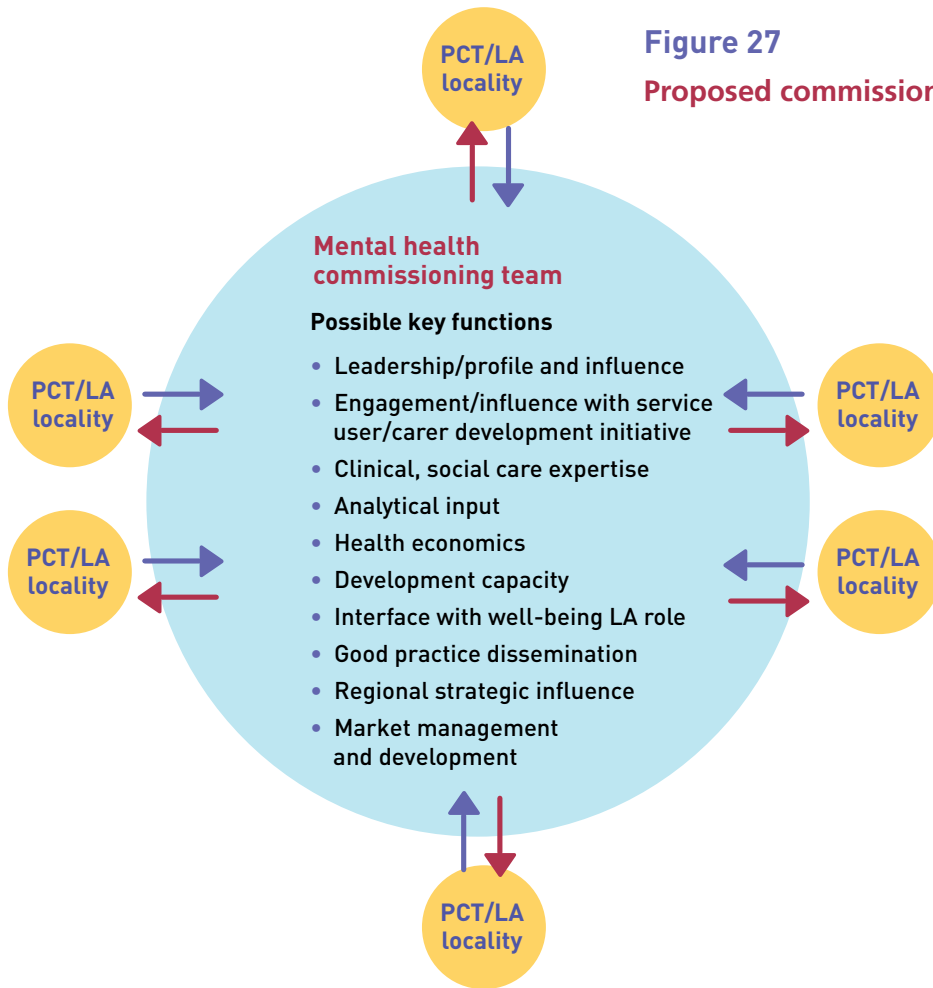
Figure 26

Advancing Quality

This initiative is intended to improve quality by providing rewards for positive patient experience and patient-reported outcomes as well as clinical outcomes.

www.advancingqualitynw.nhs.uk

Figure 27
Proposed commissioning model



cautious, partner. The proposed model is based on a contracting mechanism with individual PCTs and their LA partners. Each local partnership holds its own contract with the commissioning team and retains authority to decide on investments and priorities.

The commissioning team benefits from the 'pooling' of resources and would in our view be able to more effectively discharge the competencies outlined in WCC to achieve improved outcomes from the commissioning process.

The effect of 'pooling' commissioning resources would be to allow more senior leadership in mental health commissioning, a clearer focus of commissioning resources and a greater degree of leverage, influence and impact across a more strategic area. However, the individual nature of contracts would ensure that local priorities and goals have to be delivered.

We anticipate that individual PCT and LA partners will need to retain resources for some elements of the commissioning process. We feel that flexible working with the commissioning team would enable them also to be involved in these elements of the process to keep the spread of costs to a minimum.

Building capacity

RECOMMENDATION 3

We recommend the creation of mental health commissioning teams operating across a city region or other wider footprint and contracted by individual PCT/LA partnerships to deliver significant elements of mental health commissioning on their behalf (Figure 27).

This model (Figure 27) is consistent with the FESC. Across the North West, we may see three to five such teams being created, with precise footprints to be agreed between PCTs and local authorities (LAs).

The aim of this model is to capitalise on 'pooling' resources for the commissioning process, without compromising the statutory accountability of PCTs and LAs or their local aspirations and priorities. Others in the North West and elsewhere have used models of collaborative commissioning to achieve the 'pooling' of resources. We have heard from many of them that the main limitation of this approach is the tendency to promote progress at the pace of the slowest, or most

We also recognise that there are locally-sensitive issues such as the delivery of the well-being agenda, service user and public involvement and practice-based commissioning. Capacity would have to exist either at local or commissioning team level with flexibility to use either mechanism in different areas according to local discretion.

This smaller number of commissioning teams would also find it easier to coordinate commissioning activity across the North West for some specialist services and assist in reducing out-of-area placements.

More effective market development and management could be facilitated by fewer commissioning teams, and this new configuration could also provide better opportunities to promote innovation and disseminate good practice. It could also serve to facilitate a clearer development structure and career progression for people involved in mental health commissioning.

Developing more integrated commissioning

We believe that the new model for commissioning would enhance integrated commissioning between local partner organisations as they develop clarity on their objectives and resources as part of the contracting process.

We recognise the need to further develop the capability of the NHS to work with other bodies across government departments on mutually-important areas such as recovery, access to employment and training opportunities, benefits and criminal justice support and rehabilitation.

We believe that more focused commissioning processes would be better placed to facilitate some areas of work between PCTs, LAs and other agencies to develop more concerted approaches to these challenging issues. In many cases, the support required should be led by other agencies, using the vehicle of LSPs and LAAs as described earlier in the report. Whilst some of this is best developed locally, some would benefit from a wider approach.

Strengthened commissioning needs to work more closely with service users, carers and the public, in order to be more explicit about the wider outcomes valued by people. This smaller number of teams could operate more effectively with the proposed engagement initiatives highlighted in **Recommendations 1** and **2**, to develop new means by which service users, carers and

the public should be involved in service design, development and monitoring. Whilst the benefits to integration outlined above stem from our revised model for commissioning, we recognise that there also needs to be further development of the role of communities and the public in securing improvements to people's mental well-being. PCTs, LAs and proposed mental health commissioning teams will all need to work closely with practice-based commissioning teams to ensure local issues and feedback are prioritised and innovation encouraged.

We have been impressed by the potential of models such as Turning Point's 'Connected Care' currently being implemented in Bolton and delivering a bottom-up, community-designed approach to more integrated commissioning (**Figure 28**).

RECOMMENDATION 4

We recommend further investigation and implementation of models like 'Connected Care' as a means of developing more community-centred and integrated commissioning for health and well-being.

Developing more sophisticated mechanisms for driving service improvement

We have highlighted that mechanisms for contracting mental health services have not developed in as sophisticated a way as in some other health areas and that this in turn has hampered change.

One of the deficits is in the development and application of measurements of service user and carer experience. Another is the ability to define and measure outcomes which are important to service users and carers.

RECOMMENDATION 5

We recommend a programme of work in conjunction with service users and carers to develop and implement more service user and carer-defined measures of outcome and experience as part of the Advancing Quality initiative.

Development of these measures should be greatly aided by the existence of the service user and carer engagement development initiative and their implementation should be supported by the new commissioning model.

We have also recognised the positive work being taken forward in some local partnerships to develop measures and targets in LAAs in support of the well-being and prevention agenda.

We recognise the importance of purposeful activity to everyone, whether as a means of helping them to stay healthy, preventing them from becoming ill or helping them to recover, and we would encourage agencies to work together to promote this aspect in people's lives.

RECOMMENDATION 6

We recommend the wider use by commissioners across the North West of the measures of recovery developed and in use in the Mental Health Centre of Denver, USA.
www.reachingrecovery.org

RECOMMENDATION 7

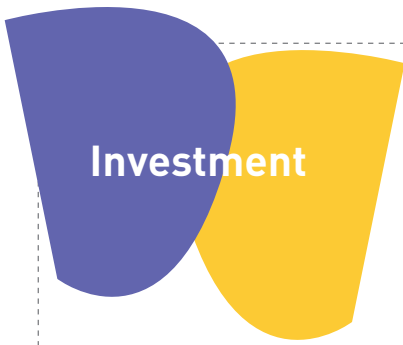
We recommend that commissioners, working with other agency partners, develop and implement more measures and targets that promote paid work, education, leisure and volunteering in support of well-being, illness prevention and recovery for those experiencing mental illness.

Figure 28

Connected Care

Turning Point's 'Connected Care' model is currently being implemented in Bolton and Hartlepool and delivering a bottom-up, community-designed approach to improvement of health, housing and social care services. This model takes the expressed needs of people living in the local community as its starting point, and invests considerable time and resources in communicating and engaging with them. When those needs have been identified, the local community is supported to design and deliver solutions using multi-agency resources.

www.turning-point.co.uk



Investment

Investment

The budget for the NHS in the North West is now around £12 billion a year, of which just over £1.5 billion (12.1 per cent) is spent on mental health services. Nationally, since 2001, there has been a 38 per cent increase in spending on mental health services for adults of working age and in the North West an increase of 46 per cent. However, the North West still lags behind.

There are at least two national sources of information on mental health spending (Mental Health Strategies and Programme Budgeting), although these are not entirely consistent. According to Mental Health Strategies, the North West region in 2006/07 spent the second-lowest amount per

weighted head of working age population – £14 per person below the national average. The other source showed all NHS spending on mental health (excluding substance misuse) per weighted head of population in the North West to be £6 below the national average. Not all PCTs were spending less than average. However, both sets of figures indicated that the amount required to bring the North West's lower-spending PCTs up to the national average would be approximately £100 million a year.

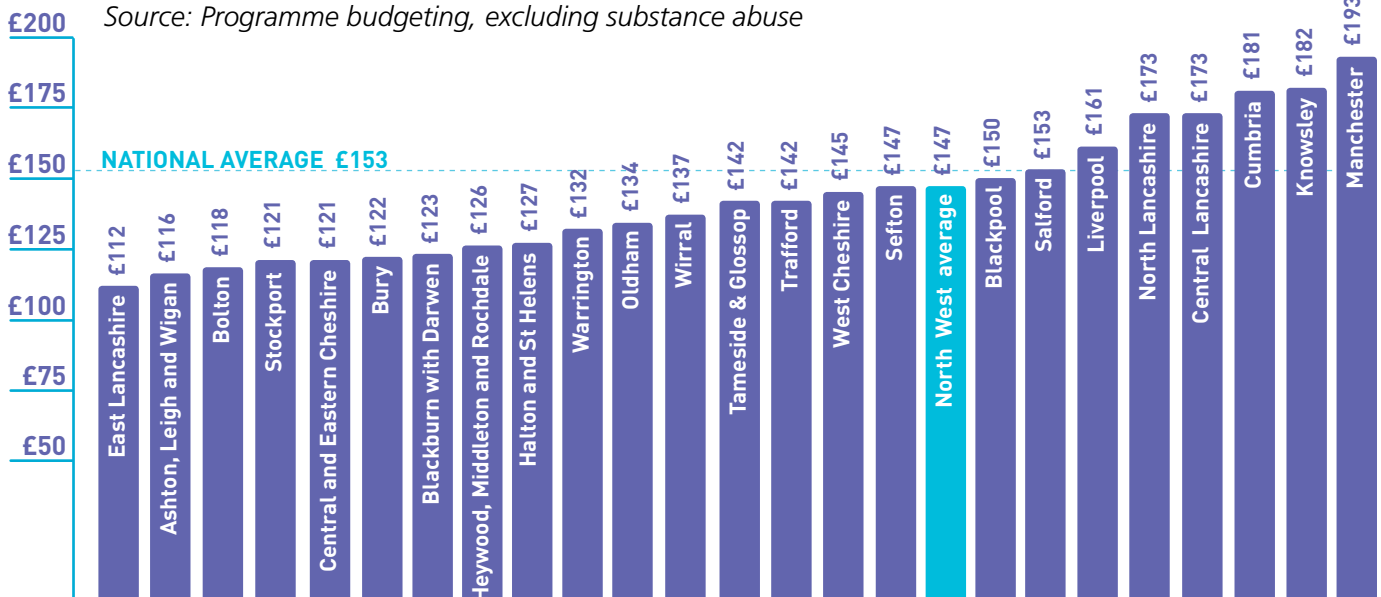
Figure 29 demonstrates the variability of investment in mental health across the PCTs in the North West with a 75 per cent difference between the lowest and highest spenders,

even after allowing for local variations of need. We accept that levels of spending do not give any indication of whether the money spent is being used efficiently or effectively. As we have already highlighted there is little or no data about outcomes and therefore the relative value derived from different levels of investment can not be gauged. However, there can be little doubt that in the many PCTs (16) that are spending less than the national average, an increase to the weighted average would represent a significant additional investment in mental health. In one PCT the additional amount would be as much as £15 million whilst in another nine PCTs it would be £5 million or more.

Figure 29

PCT spending on mental health in 2006/07 per weighted head of population

Source: Programme budgeting, excluding substance abuse



How can we change patterns of investment?

We are in no doubt that some PCTs need to increase their investment in mental health if the required improvements are to be made. Better information on investment levels should also be available more widely to allow greater accountability by PCTs to their populations.

More-empowered service users, carers and the general public would be able to play a much more active role in holding the PCTs to account for their levels of investment. The proposed new commissioning model should also enable a more-focused approach to deliver greater value for money.

However, to facilitate this process and to enhance the ability to hold PCTs to account for levels of investment, it will be necessary to ensure that simple, clear, financially transparent and consistent data on spending is made widely available.

We have already highlighted that most NHS resources are committed to treating those with severe and enduring mental illness and that relatively little is invested in mild to moderate problems, prevention or promoting better mental health.

The national survey of investment in mental health services commissioned by the DH showed investment in illness prevention or well-being indicates 0.1 per cent being committed to these areas whilst our North West survey showed this to be 0.2 per cent (Figure 6, on page 9). Across PCTs in the North West, we found a range from 8p to £1.40 per head on well-being and prevention, with spending overall from £88 to £200 per head.

Greater investment is required at this end of the spectrum to improve mental health and to lower the personal and societal costs of mental illness and poor mental health.

We believe that there are further efficiencies to be achieved in mental illness services and that a more-focused approach to commissioning would help to achieve this. However, there are also significant deficits in some mental illness services and simply withdrawing money from efficiencies made in these services could act as a disincentive to the improvements needed in service quality.

As a general principle we think that efficiencies here should be reinvested to support the improving quality agenda. We recognise that in those PCTs that are already investing at, or above, the national average, this may not be possible.

In some areas, a proportion of any additional investment will be required to support the quality of services to those who are ill, but a significant focus for new resources should be to support the prevention and well-being agendas. Strengthened integrated commissioning should help to achieve this.

RECOMMENDATION 8

We recommend that financially transparent comparative information on levels of investment by PCTs on well-being, mental health prevention, and mental illness treatment, including recovery, be made publicly available to ensure greater accountability for investment choices.

RECOMMENDATION 9

We recommend that commissioners critically review their expenditure on well-being, illness prevention and recovery, to ensure that they are maximising the opportunity to lower the personal and societal costs of mental illness and poor mental health.

Developing staff

In our presentation of long-standing problems we highlighted the challenge of staff attitudes and working practices for the range, nature and quality of services which are offered in both primary and secondary care.

The problems in this area have been recognised in many policy and guidance documents from national to local level.

In 2005 and 2007, the DH published documents entitled *New Ways of Working* to highlight ways in which staff needed to work differently to support new service models. *Delivering Race Equality in Mental Health* published by the DH in 2005 highlighted issues such as stigma and discrimination.

The need to offer a wider range of support beyond clinical services has also been well recognised in national policy, including *Our Health, Our Care, Our Say* particularly in relation to social care, prevention, well-being and positive physical and mental health. The strengths-based recovery model for mental health services also recognises this need.

The impact of policy in all these areas has been limited by the lack of an effective means of driving it forward and then measuring its success. Again the focus has been largely on inputs, such as workforce numbers, rather than the effect these new roles have had on service users' experience.

How can we enable staff to deliver better services?

We believe that most of the policy and guidance relating to workforce development is very positive and there is much to agree with. However, the desired outcomes of much of this policy and guidance are not built into commissioning plans or service outcome measures. The tendency therefore is for these policies to be readily adopted by those who need them least and easily avoided by those who need them most.

We therefore believe that the success of workforce policy as a means of improving quality is directly linked to our earlier recommendations about the effectiveness of commissioning. In short, if commissioners required services to deliver more outcomes valued by service users and carers, providers would then need to adjust the make up and practices of their workforce to deliver these.

Strengthened commissioning needs to be explicit about the outcomes required of a strengths-based recovery model, including employment and education. The role of providers is to work with service users and carers to determine what type of workforce is required to produce these agreed outcomes.

This focus would also serve to promote the development of new paid roles such as peer mentors, that value the contribution of

people with personal experience of mental illness and would offer greater opportunities to support service users in a return to paid employment built upon their experiences. We also believe that service users and carers have more of a role to play in the appointment of staff and the ongoing assessment of their capability and competence.

RECOMMENDATION 10

We recommend that paid roles which value the service user experience are developed and implemented more widely and that service users and carers are more involved in the appointment of staff and the on-going assessment of their competence and capability.

During our review we have met and heard of many staff across all organisations who are working hard to try to deliver a personalised and individual service to service users and carers.

However, we have also received frequent feedback from staff, service users and carers, that institutional and professional attitudes and practices that stigmatise people with mental health problems still pose a significant challenge across the mental health community.

In a recent study carried out by Rethink called 'Stigma Shout', health professionals were identified by service users and carers as one of the main groups whose attitudes, if inappropriate, had serious implications for them.

RECOMMENDATION 11

We recommend that the recently-launched 'Time to Change' campaign is used by mental health service providers as an opportunity to work with staff to challenge attitudes and practices and further promote new ways of thinking and working.

www.time-to-change.co.uk

Earlier in this report we quoted the words of a service user who told us: *"I didn't feel welcome when I went to hospital. It seemed as if I was a nuisance."*

Whilst we have only selected this one quote, it represents the sentiment of many comments made during our review. We have already highlighted that many staff feel pressured by their working environment and the challenges they face.

The attitudes described to us can in our view often result from working with distressed people who often have complex needs in difficult settings.

RECOMMENDATION 12

We recommend investing more in the development, training, supervision and coaching of staff, to better enable them to deliver strengths-based approaches to recovery.

“ Institutional and professional attitudes and practices that stigmatise people with mental health problems, still pose a significant challenge across the mental health community. ”

Conclusion

Conclusion

This report has been developed following a year-long programme of engagement, discussion, debate and analysis with stakeholders across the mental health community in the North West.

Our extensive engagement programme identified that, whilst there has been commendable progress, in some areas and on some issues a number of long-standing problems remain. These problems are causing great difficulties for the many thousands of people who use, or care for someone who uses, mental health services.

We found that some important services are not always available or accessible and that there is a significant variance in the quality of services across the North West.

Investment has been focused on treating people with a serious and long-standing mental illness, with relatively little being invested on those with mild to moderate difficulties, on preventing illness or helping people to stay mentally well. Problems with staff attitudes and working practices were also raised.

We looked at the mechanisms which the NHS and other agencies have been using to

address these problems and have sought to identify why they have not been able to bring about the expected improvements more quickly.

We found that the engagement of service users, carers and the public in decisions about the design, delivery and evaluation of services is not as well developed as it needs to be.

Commissioning – one of the key mechanisms for improvement in the NHS – is not functioning effectively in many places. We found that levels of investment in mental health services are varied and that some PCTs in the North West lag behind the national average by considerable amounts.

We also found that staff often struggled to provide care and support in partnership with service users and carers based on a strengths-based recovery model. People often described feeling 'done to' rather than 'worked with'.

We have made a set of recommendations which we believe will strengthen the mechanisms for engaging service users, carers and communities, strengthen commissioning and develop the workforce.

We have seen some different and more successful ways of

doing things with innovations from within the North West and around the world. The challenge is to ensure that the best is available more consistently across the North West.

We believe that our recommendations, if implemented, will better harness and focus the enthusiasm and commitment evident across the North West to ensure that this challenge is met.

“ The challenge is to ensure that the best is available more consistently across the North West. ”

Summary of recommendations

RECOMMENDATION 1

We recommend the strategic health authority uses its leadership and influence to create a cross-agency programme to support and scrutinise significant performance improvements in service user, carer and public engagement in mental health. This should directly address the known organisational, managerial, professional and cultural barriers to effective engagement.

RECOMMENDATION 2

We recommend the strategic health authority uses its leadership and influence to support the North West NHS and other partners to establish a service user and carer engagement development initiative. This should enable service users, carers and communities to participate effectively as equal partners in the design, delivery and evaluation of services.

RECOMMENDATION 3

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active internet links is available at:

www.northwest.nhs.uk/projects/mental_health_commission/

This webpage will also direct you
to additional information, reports and
references cited in this report.